

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G811		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/02/2015	
NAME OF PROVIDER OR SUPPLIER RES-CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135			
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W 0000 Bldg. 00	<p>This visit was for an investigation of complaint #IN00181507.</p> <p>Complaint #IN00181507: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W149, W153, W154 and W267.</p> <p>Dates of Survey: 9/15, 9/16 and 10/2/15</p> <p>Facility Number: 013405 Provider Number: 15G811 AIM Number: 201267570</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2-5. Quality Review of this report completed by #15068 on 10/9/15.</p>		W 0000				
W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on interview and record review for 2 additional clients (L and S), the facility failed to implement its written policy and procedures to prevent exploitation of the clients. The facility failed to implement its written policy and procedures to</p>		W 0149	<p>The facility develops and implements written policies and procedures that prohibit mistreatment, neglect and abuse of the client. All staff were retrained on policy and procedure regarding reporting abuse,</p>		10/24/2015	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	<p>ensure facility staff reported all allegations of abuse, neglect, and/or exploitation immediately to the administrator and/or to state officials (Bureau of Developmental Disabilities-BDDS and/or Adult Protective Services-APS). The facility failed to implement its policy and procedures to conduct thorough investigations in regard to allegations of staff to client abuse/neglect, mistreatment and/or exploitation of clients.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 9/15/15 at 3:40 PM. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive):</p> <p>-8/30/15 "On August 30, 2015 allegation was made that staff member, [Residential Manager-RM #1], Residential Manager has been having an inappropriate relationship with [client S]. The allegations were reported to another staff member by [client S]. He reported that he and [RM #1] have kissed and held hands and that the relationship has gone on for approximately one month...." The 8/30/15 reportable incident report indicated RM #1 was suspended pending</p>				<p>neglect and exploitation. All staff were retrained on policy and procedure regarding Professional Boundaries. This training occurred on 10/6/2015. This includes, but is not limited to, immediate reporting requirements for any allegation of abuse, neglect and exploitation of the clients that are served, and ResCare policy requirements for Professional Boundaries between clients and employees. The ResCare Quality Assurance Manager, was retrained on Policy and Procedure requirements for conducting complete and thorough investigations. This includes, but is not limited to ensuring that all clients are interviewed within the scope of any given investigation, and as it is appropriate and necessary to do so. Interviewing all staff that involved with an issue, or as it is necessary to provide a global overview of an incident to ensure that an investigation is complete. All staff names and statements, that were interviewed and as appropriate, will be included in the investigative summary report. ***Please note that it may not be necessary to interview every single client, or every single staff person depending on the nature of the allegation or the investigation. When it is necessary, all clients and staff will be interviewed for complete investigative purposes. ResCare Administration will conduct active</p>		

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	<p>an investigation.</p> <p>The facility's 9/9/15 follow-up report to the 8/30/15 reportable incident report indicated "...Investigation was unsubstantiated."</p> <p>The facility's 8/30/15 Investigative Summary indicated "[Direct Support Professional-DSP #1] reports that approximately 2 and half weeks ago, She (sic) came in early to help cover a call off on second shift. She (DSP #1) states that [RM #1] was [client S] 1:1 staff (one staff to one client) staff. She states that she was assigned [client S] and relieved [RM #1]. [DSP #1] reports that as [RM #1] was leaving [client S's] room, she (RM #1) told him she would see him later and that [client S] winked at [RM #1] as she left. [DSP #1] states that after [RM #1] left the room, [client S] stated that he could trust her (DSP #1) and wanted to tell her something. [Client S] then proceeded to confide in her that he had a girlfriend on staff. He told her (DSP #1) that he had kissed and french kissed the staff member he referred to as T-Baby. [DSP #1] states that [client S] told he (sic) that T-Baby was [RM #1] and that [client S] understood that staff could get in big trouble for having that type of a relationship with him...[DSP #1] reports that she never mentioned this</p>				<p>treatment observations, at least three times per week, ensuring that an observation is completed at least one time per each shift. This is to ensure that staff are interacting appropriately with clients, that staff understand the professional boundaries necessary to appropriately do their jobs, as well as always observing for ongoing active treatment. In addition, active treatment observations will be utilized as opportunities to provide immediate feedback and retraining for staff working with the clients, at the time of the observation. Observations will be documented on the active treatment observation form. ResCare administrative staff will conduct a weekly peer review/debriefing meeting to determine any training and follow up that will be needed. These observations and debriefings will occur on an ongoing basis. All investigations will be submitted to the Executive Director for review. Investigations will be reviewed for completion, accuracy and thoroughness, per regulation and policy. Date of completion: 10/24/2015</p> <p>Persons Responsible: Executive Director, Program Manager, QIDP's, Quality Assurance, Nursing Manager</p>		

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	<p>conversation to anyone. She states that [client S] made veiled threats to her, telling her he would get even if she ever told anyone. [DSP #1] states that [RM #2], RM, her direct supervisor, had mentioned to her that [client S] had stated that he had a girlfriend on staff over the past weekend. She states that she was afraid someone would be falsely accused, so she decided to report what [client S] had confided in her. [DSP #1] further reported that not only was she afraid of [client S], she was afraid that [RM #1], RM, [RM #3], RM and [staff #2] would retaliate against her if she told. [DSP #1] stated that they were all related and that she was afraid that they would allow [client S] to physically harm her if she told what [client S] had told her...."</p> <p>The facility's 8/30/15 investigation indicated RM #1 was interviewed. RM #1's undated witness summary indicated "[RM #1] denied having an inappropriate relationship with [client S]. She reports that before she was promoted to Resident Manager she had been [client S's] 1:1 staff maybe 9 or 10 times. She states that since her promotion she has never assigned herself to be his 1:1 staff. She stated that she has only been with [client S] while her staff took breaks and never for more than 15 minutes. [RM #1] was presented with [client S's] 5 minute check</p>						

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	<p>logs and agreed that she had logged in as his 1:1 staff on many occasions sometimes for several hours at a time, since being resident manager. [RM #1] stated that [client S] had sent her text messages to her personal cell phone. She reported that she had deleted that (sic) text messages but that she could get them from her cell service provider and would turn them in. As of the writing of this report, [RM #1] has failed to present the print out of the text messages she received from [client S]. [RM #1] reports she received the text messages in mid August and that she received texts from him on 9 or 10 different occasions. She states that the messages were inappropriate in nature; that he missed her, asked her when she was coming in and told her he hoped she was having a nice day...She states that she had not reported the text messages to anyone. [RM #1] further stated that she was aware [client S] had an employee phone list, had ghost money that was not reported on his financials, had the code to the gate and was texting other staff as well and she failed to report all of these things because she did not want [client S] to get into trouble...."</p> <p>The facility's 8/30/15 reportable incident report indicated DSP #3 reported client S told her he was "...talking to someone'</p>						

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	<p>she states that she questioned him but that he would not tell her who this person was but she felt he was referring to a staff member...and that he (client S) pays close attention to [RM #1], making certain he speaks to her when she arrives. She (DSP #3) states that [client S] has a close relationship with [RM #1], RM and [DSP #4], stating it is not professional but like 'they are buds.' She states that she immediately reported this information to her direct supervisor, [RM #3], Resident Manager...."</p> <p>The facility's 8/30/15 investigation indicated RM #3 was interviewed. RM #3's undated summary indicated "[RM #3] reports that [client S] had told him on several occasions in the past two weeks that he has a girl on staff he is 'talking to.' [RM #3] states that [client S] told him they were going to hook up when he is released and that he has to be good so he can get (sic) of here. [RM #3] states that he thought that [client S] was blowing smoke and that he played it off. [RM #3] states that he did not report this information. [RM #3] further states that [DSP #3] had reported to him that [client S] had told her he was seeing a staff member but that he did not report this information to his supervisor."</p> <p>The facility's 8/30/15 investigation</p>						

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	indicated DSP #5 was interviewed. DSP #5's undated summary indicated he had worked as client S's 1:1 staff when he (DSP #5) saw client S texting from his tablet computer. DSP #5's summary indicated he saw staff's names on the client's computer. DSP #5's summary indicated "...[client S] also confided in him that he has what he calls ghost money. [DSP #5] explains that [client S] confided in him that ghost money is cash that he gets from staff as gifts or for payment for burning music CDs or downloading movies for staff onto portable drives, that is not recorded on his financials. [DSP #5] states [client S] did not tell him what staff had given him ghost money. [DSP #5] states that [client S] told him he had the code to the back security gate off the gym. [Client S] did not tell him how he got the code. [DSP #5] reports that [client S] had never said anything to him regarding a girlfriend but that when he reported to his direct supervisor, [RM #3], RM on Thursday (sic) regarding the texting, the gate code and the ghost money, that [RM #3] told him he (RM #3) suspected that [RM #1], RM was [client S's] girlfriend. [DSP #5] further reports that after reporting this information to [RM #3], he was concerned that [RM #3] had not followed up so he reported to [RM #4], RM the following day."						

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	<p>The facility's 8/30/15 investigation indicated DSP #6 was interviewed in regard to the allegation of abuse. DSP #6's witness statement indicated client S had told DSP #6 about the "ghost money." DSP #6's summary indicated "...She (DSP #6) describes it as money he gets from staff for burning music CD's...She (DSP #6) further states that [client S] has told her that [RM #5], RM and [DSP #2], DSP have promised to give him an automobile when he is released from ResCare. [DSP #6] states that she (sic) [client S] has what she referred to as a crush on [RM #1]...." DSP #6's summary indicated the staff knew about client S having the code to the gate. The staff's summary also indicated "...she heard [RM #1] on the phone in the employee break room on Saturday and had stated that she needed to remove something from [client S's] room before it was found. [DSP #6] reports that she thought she (RM #1) was speaking to [RM #5] on the phone, because she could hear [RM #5's] voice on (sic) through the phone...." The DSP's summary indicated she did not report client S's having the code to the gate to her supervisor.</p> <p>The facility's 8/30/15 summary indicated DSP #7 was interviewed. DSP #7's</p>						

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	<p>summary indicated client S had told the staff person about his "ghost money" from where client S made music CDs for staff. DSP #7's witness statement indicated DSP #7 had bought the client a pop on one occasion when they were at the county fair. DSP #7's summary indicated she did not purchase any CDs from client S. DSP #7's summary also indicated client S was with RM #1 "a lot." The summary indicated "...[DSP #7] states that she had witnessed [RM #1] dancing for [client S]. She (DSP #7) reports that she walked into [client S's] room and that he was video recording [RM #1] dancing on his tablet. She states that when [RM #1] saw her, she was very surprised and told [client S] that he must erase the video. [DSP #7] states that she did not report this to anyone." The facility's 8/30/15 investigation indicated the following:</p> <p>"Factual Findings: The allegations of sexual abuse are unsubstantiated as both [RM #1] and [client S] deny allegations. It is evident that [RM #1], RM, has violated ResCare policy in that she had direct knowledge that [client S] was texting staff including herself, that [client S] had the security access code to the back gate and that he was in possession of what he referred to as ghost money, that was not recorded on his financial</p>						

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	<p>records.</p> <p>Conclusion: It is determined that [RM #1] has violated ResCare policy in that she had direct knowledge that [client S] was non compliant with his Individual Support Plan as well as his Behavioral Support Plan, that she has failed to report this non compliance and has undermined his program." The facility's 8/30/15 investigation indicated the facility failed to interview all clients at the facility in regard to "ghost money" and/or to see if any other clients were being exploited by facility staff and/or abused. The facility's 8/30/15 investigation indicated the facility did not include client S's witness statement and/or summary, did not interview all staff who worked at the facility to determine who participated in the exploitation of client S and/or knew about client S's and RM #1's relationship. The facility's 8/30/15 investigation did not indicate DSP #2 was interviewed in regard to her involvement and/or indicate RM #5 was interviewed in regard to her involvement of the exploitation of client S. The facility's 8/30/15 investigation did not indicate any recommendations in regard to DSPs and/or RMs not reporting allegations of abuse and/or exploitation to the administrator immediately.</p> <p>- "On 9/1/15 at approximately 9:37 pm it was alleged that [client S] reported to</p>						

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	<p>RM [RM #5] that DSP [DSP #3] had performed oral sex on him. DSP [DSP #7] told her peer. DSP [DSP #3] was immediately suspended pending the outcome of the investigation. Though (sic) the course of the investigation [RM #5] denies an allegation was made. [Client S] denies any allegation of sexual abuse and any allegation was ever made. The outcome of the investigation is unsubstantiated."</p> <p>The facility's 9/1/15 Investigation Summary indicated "[RM #6] reports that he was approached by [DSP #8], DSP, who reported to him that [DSP #7], DSP had told her that DSP [DSP #3] had 'given [client S] head.' [RM #6] clarified that [DSP #8] was referring to oral sex. [RM #6] stated that he spoke to [DSP #7] and that she reported to him that RM [RM #5] had informed her of this earlier in the evening."</p> <p>The facility's 9/1/15 investigation indicated DSP #9 was interviewed in regard to the allegation of sexual abuse. DSP #9's undated witness summary indicated DSP #7 had told her about DSP #7 questioning client S about a girlfriend he had on the second shift. DSP #9's statement indicated DSP #7 also told DSP #9 client S had stated he and RM #1 "had only kissed." The 9/1/15</p>						

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	<p>investigation indicated "...[DSP #9] states that [DSP #7] continued to question [client S] about [DSP #3]. [DSP #7] reported to [DSP #9] that he [client S] only grinned when she mentioned [DSP #3]."</p> <p>The facility's 9/1/15 investigation indicated RM #5 denied knowing anything about the allegation of sexual abuse against DSP #3. RM #5's undated witness summary indicated "...When questioned regarding the conversation she had with [DSP #7] she stated that she had heard something about [client S] and [DSP #3] but could not remember who told her. When asked who she had discussed the investigation with, she (RM #5) replied that she had only spoken to [DSP #7] about it. When questioned if she had discussed the matter with [client S], she stated that she had spoke (sic) to him...She said that [client S] had told her that he feels like staff is going to be hurt and its his fault. She then stated that [client S] had been talking to her regarding [RM #1] and getting candy and soda from staff that they were speaking in hypotheticals...." RM #5's witness statement indicated client S did not make an allegation of abuse against DSP #3 and/or RM #1. The facility's investigation indicated "...[RM #5] reports that she understands ResCare</p>						

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	<p>policy regarding cooperating with investigations and that her actions in speaking with [client S] and [DSP #7] were a direct violation of policy. [DSP #3], DSP denies having any sexual contact with [client S]. Factual Findings: The allegations of sexual abuse are unsubstantiated. Conclusion: It is determined through interviews with staff and [client S] that sexual abuse did (sic) not occur. The allegations were made as a direct result of [RM #5's] RM, and [DSP #7's], DSP violating Res Care policy regarding cooperating with the investigation process." The facility's 9/1/15 investigation indicated the facility did not include/indicate client S's interview, and/or did not indicate other clients who lived at the facility were interviewed in regard to staff to client sexual abuse. The facility's investigation indicated the facility's investigation did not include the witness summary from staff DSP #3.</p> <p>-8/30/15 investigation indicated "During the course of an abuse investigation, allegation regarding policy violations were made, including but not limited to; staff providing muscle relaxers to consumers, staff making purchases of pirated music and movies from consumers, staff bringing in candy, sugary soft drinks and energy drinks for</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G811		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 10/02/2015	
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	<p>consumers, staff and consumers texting one another on personal cell phones, consumers selling electronics to staff, staff furnishing consumers with electronic devices and staff failing to report policy violations." Review of the facility's reportable incident reports from 8/1/15 to the present indicated the facility did not report the above mentioned 8/30/15 allegation of staff to client abuse, mistreatment and/or exploitation to Bureau of Developmental Disabilities (BDDS) and to Adult Protective Services (APS).</p> <p>The facility's 8/30/15 investigation indicated DSP #2 was interviewed. DSP #2's undated witness summary indicated "[DSP #2] denies having any knowledge of consumers having possessions of contraband. She states that she several months ago she (sic) gave [client N] a mountain dew...[DSP #2] reported that she had spoken to [client S] regarding a tablet computer in his possession. She states that she asked [client S] where the tablet came from and he told her it was a tablet he brought with him from [name of facility] and that he had removed the case...[DSP #2] stated that [RM #5] first told her about pills being found in [client S's] possession. [DSP #2] was later questioned on (sic) reported at that time that she had brought a new tablet to</p>						

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	<p>[client S], she stated that she was paying for the tablet on her [name of company] cellular account. [DSP #2] reported that she had not removed that tablet from campus and has no idea where the tablet is now." The facility's investigation also indicated DSP #10 had brought client S a candy bar "a month ago."</p> <p>The facility's 8/30/15 investigation indicated DSP #7 admitted to buying client S a pop while on an outing. The facility's investigation indicated "...[DSP #7] reports that [client S] had offered to burn a music CD for her but that she refused to accept. She states that [client S] had told her about ghost money...[DSP #7] reports that she did not report this to her supervisor and...[DSP #7] states that she had seen [client S] with a new tablet computer and that she asked him about it. He told her that he had removed the case from the tablet he brought with him from [name of facility]. [DSP #7] reports that she knew it was not the same but reports that she did not report this either...." The facility's 8/30/15 investigation indicated DSP #7 knew client S had the code to the gate, and saw RM #1 dancing while client S videotaped RM #1. The facility's investigation indicated DSP #7 indicated she did not report the above mentioned incidents.</p>						

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	<p>The facility's 8/30/15 investigation indicated RM #3 admitted not reporting seeing client S with a sugary drink in his bedroom, and did not report he knew client S had the code to the back gate. The facility's investigation indicated RM #3 admitted he did not report client S's telling him he had a girlfriend he was talking to and they had planned to "hook up" when he left the facility. The facility's 8/30/15 investigation indicated RM #3 had admitted to knowing client S was texting staff and knew the back gate code. The facility's investigation also indicated RM #3 was aware "...that a consumer had been trafficking (staff doing favors and/or paying the client for CDs and/or movies) with staff..." The facility's 8/30/15 investigation indicated "...It is determined through evidence and interviews that [DSP #2], [DSP #10], [DSP #7], RM #3, [DSP #1], [RM #1] and [RM #5] have all violated ResCare policy in that they failed to follow Individual Support Plans, Behavior Support Plans and failed to report either allegations of policy violations to their immediate supervisors or administration. Conclusion: It is recommended that the above mentioned personal (sic) be terminated from employment for policy violations."</p> <p>Client S's 5 minute checks (one on one</p>						

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	<p>staffing logs) were reviewed on 9/15/15 at 12:35 PM. Client S's 5 minute checks indicated RM #1 was client S's 1:1 staff on the following dates/times:</p> <p>-8/4/15 4:00 PM to 9:00 PM and 10:50 PM to 11:10 PM.</p> <p>-8/6/15 4:00 PM to 10:10 PM and from 10:35 PM to 11:45 PM.</p> <p>-8/9/15 3:55 PM to 7:40 PM, 8:05 PM to 9:55 PM and from 10:10 PM to 11:55 PM.</p> <p>-8/10/15 10:35 PM to 11:55 PM.</p> <p>-8/12/15 4:10 PM to 7:55 PM and from 8:15 PM to 11:10 PM.</p> <p>-8/16/15 8:50 PM to 9:40 PM and from 10:10 PM to 10:25 PM.</p> <p>-8/17/15 8:45 PM to 10:10 PM and from 10:15 PM to 10:30 PM.</p> <p>-8/22/15 5:10 PM to 7:00 PM.</p> <p>-8/23/15 9:50 PM to 10:05 PM.</p> <p>-8/27/15 5:05 PM to 6:20 PM and from 9:20 PM to 9:40 PM.</p> <p>-8/28/15 5:45 PM to 6:15 PM.</p> <p>RM #1's personnel record was reviewed on 9/16/15 at 12:10 PM. RM #1's personnel record indicated the RM was terminated from her employment with ResCare on 9/14/15. The facility's 9/14/15 Corrective Action Form indicated RM #1 was aware of a client having access to a gate code, and failed to report allegations of abuse/neglect to her</p>						

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	<p>supervisor and/or management staff.</p> <p>The facility's inservice training records were reviewed on 9/16/15 at 12:10 PM. The facility's 9/8/15 Inservice Sign-in Sheet indicated all facility staff were retrained in regard to reporting abuse/neglect and policy violations and "Professional Boundaries."</p> <p>Client S's record was reviewed on 9/16/15 at 1:05 PM. Client S's 7/21/15 Interdisciplinary Team (IDT) Meeting note indicated "[Client S] has made progress working with his 1:1 staffing while on campus to stay busy and positive. He has not targeted any female staff to date...Recommendations: The IDT agrees that [client S's] 1:1 staff does not have to be a male staff on campus. When in the community [client S] is still 2:1 staffing, one of his staff must be male due to a history of bolting, and one of his staff may drive...."</p> <p>Client S's 9/8/15 IDT note indicated "On September 8, 2015 [client S] expressed to his IDT that he would like to leave services today...By signing himself out today [client S] understands that ResCare will no longer have responsibility for his care or supervision. [Client S] expressed that he would like to go to either [name of shelter and address] in [name of city]</p>						

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	<p>or [name of shelter and address] in [name of city]. ResCare Administration has agreed to assist with his transport...."</p> <p>Interview with client E on 9/15/15 at 6:55 PM indicated clients were not allowed to date facility staff. Client E indicated he would report staff if they asked him to do a favor for money. When asked what ghost money was, client E stated "I don't know what it is." Client E indicated clients were not allowed to have or know the codes to the gate.</p> <p>Interview with client K on 9/16/15 at 9:22 AM indicated he did not know what ghost money was. When asked if a client was allowed to date a staff person, client K stated "No." Client K indicated he had not received any money from staff in regard to doing favors.</p> <p>Interview with client J on 9/16/15 at 9:32 AM indicated facility staff had not asked the client to do a favor for them in exchange for money. When asked what ghost money was client J stated "When staff gives you money out of their pocket." Client J was not able to provide any additional information as the client indicated his money was kept in the filing cabinet in the closet.</p> <p>Interview with DSP #12 on 9/16/15 at</p>						

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	<p>9:39 AM indicated he had heard the phrase ghost money but did not know what it was. DSP #12 indicated he had been interviewed by facility's administrative staff in regard to an allegation of staff to client sexual abuse. DSP #12 indicated he had not witnessed staff being too friendly with clients.</p> <p>Interview with DSP #11 on 9/16/15 at 9:49 AM indicated he was not aware of any staff going with a client. DSP #11 indicated it was against the facility's policy for a staff to date a client. DSP #11 indicated client S used to have male 1:1 staffing but it had changed recently.</p> <p>Interview with DSP #5 on 9/16/15 at 10:00 AM indicated clients were not allowed to date staff. DSP #5 indicated clients were not allowed to have the codes to the gate. When asked what ghost money was, DSP #5 stated "[Client S] was selling burned CDs to get money that was not tracked." DSP #5 stated he had "Not witnessed" this occurring. When asked if DSP #5 was aware of staff being too friendly with clients, DSP #5 stated "Just rumors and that was reported."</p> <p>Interview with RM #3 on 9/16/15 at 10:16 AM indicated clients were not to have codes to the gate. RM #3 indicated</p>						

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	<p>he was aware client S had the code to the gate and the code was changed. RM #3 indicated facility staff were not allowed to date clients per the facility's policy. When asked if RM #3 was aware of staff dating a client, RM #3 stated "Not until the investigation took place." When asked what ghost money was, RM #3 stated "No idea." When asked if he had been made aware of any incidents when staff were too friendly with clients, RM #3 stated "Never been made aware of it or seen it." RM #3 indicated he was aware an allegation had been made against a staff person.</p> <p>Interview with administrative staff #1, the Program Manager (PM), the Qualified Intellectual Disabilities Professional (QIDP) and Quality Assurance (QA) staff #1 on 9/16/15 at 1:09 PM and at 1:55 PM indicated client S no longer lived at the facility. Administrative staff #1 and the QIDP indicated client S signed himself out and left the facility. The QIDP indicated client had planned out where he was going to go. The QIDP indicated the IDT and BDDS tried to talk the client out of leaving. The QIDP indicated he took the client to another city where the client wanted to go to a shelter. The QIDP indicated the clients had since then showed up in another city, at his previous</p>						

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	<p>placement, and had contacted Social Security to get his check signed over to him. Administrative staff #1 and the QA staff #1 indicated the facility interviewed all staff at the facility. QA staff #1 indicated she did not include all the interviews in her investigation of staff to client sexual abuse and/or exploitation. QA staff #1 also indicated client S was interviewed but his statement was not part of the 8/30/15 investigations. QA staff #1 and administrative staff #1 indicated no other clients were interviewed in regard to the allegations of staff to client sexual abuse and/or exploitation. Administrative staff #1 indicated the facility's investigations should have included all staff interviews. Administrative staff #1 indicated more investigations were started as a result of additional allegations made during the investigation. The PM, administrative staff #1 and QA staff #1 indicated client S was texting facility staff from a computer tablet which was given to the client. Administrative staff indicated the client was taking orders for burning CDs and downloading movies from staff for which the facility staff were paying the client. Administrative staff #1 indicated the money client S made was not being documented on the client's financial log. Administrative staff #1 and the QA staff indicated facility staff and the RMs did</p>						

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	<p>not immediately report their concerns in regard to RM #1's relationship with client S, exploitation of the client, and/or their concerns regarding the client knowing the codes to the gate, to the administrator. Administrative staff #1 and the QA staff indicated they did not know how client S received the codes. The QIDP, PM, administrative staff #1 and the QA staff stated client S's functioning level was "very high." Administrative staff #1 stated client S was able to "manipulate staff to get what he wanted." QA staff #1 and administrative staff #1 stated the facility was not able to "prove sexual abuse" between RM #1 and client S. Administrative staff #1 indicated 4 staff had been terminated in regard to the 8/30/15 and 9/1/15 allegations of staff to client abuse within the last 24 hours. Administrative staff #1 indicated 3 RMs had been terminated and 1 DSP. Administrative staff indicated corrective action was going to be taken with RM #3. Administrative staff #1 stated RM #3 was going to be placed on "Final action." When asked why did client S leave the facility, administrative staff #1 stated "he was running this racket in [name of previous facility]. The trafficking ring was busted up. He was upset his trafficking was stopped and his 1:1 staffing was stopped." Administrative staff #1 indicated when client S was 1:1</p>						

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	<p>with staff, "He had a free pass to do what he wanted." Administrative staff #1 and QA staff #1 stated client S was "exploited by staff" as DSP #2 brought the client a computer tablet to download movies and burn CDs for staff. QA staff #1, PM and administrative staff #1 indicated facility staff had been retrained on "Professional Boundaries" and reporting all allegations of abuse/neglect. QA staff #1 and administrative staff #1 indicated facility staff were buying the client pop, candy and computer items. QA staff #1 indicated client S admitted he was getting things from staff but would not identify who had given him things and/or who was purchasing CDs/downloaded movies from him. Administrative staff #1 and QA staff #1 stated "the tablet came up missing. Someone removed it from him." QA staff #1 indicated they did not conduct an investigation in regard to RM #1 dancing for client S. QA staff #1 indicated client S's 5 minute checks indicated RM #1 was working as client S's one on one staff person when RM #1 indicated she had not worked as the client's 1:1 staff person. QA staff #1 and the administrative staff #1 indicated the facility reported the 9/1/15 allegations of staff to client abuse/exploitation to state officials. QA staff #1 and/or administrative staff #1 did not provide any additional documentation in regard to</p>						

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	<p>the 9/1/15 allegation of exploitation/abuse.</p> <p>The facility's policy and procedures were reviewed on 9/15/15 at 1:50 PM and on 9/16/15 at 12:05 PM. The facility's 4/30/15 policy entitled Abuse, neglect and & (and) Exploitation (ANE) indicated "ResCare will ensure all persons served are treated with dignity and respect. Ensure that all persons served are free from abuse, neglect, or exploitation...Ensure all incidents of abuse, neglect, and exploitation are reported to the appropriate authority as defined by state and local regulations...." The facility's 4/30/15 policy indicated "'Exploitation' means the fraudulent or otherwise illegal, unauthorized, or improper act or process of an individual, including a caregiver of fiduciary that uses the resources of a person we support for monetary or personal benefit, profit, or gain,...." The facility's policy and procedures indicated "...All employees will immediately report any allegation of suspicion of abuse, neglect or exploitation...to the first supervisor in the chain of command that is not involved in the incident...." The facility's 4/30/15 policy indicated "...All alleged or suspected abuse, neglect, and/or exploitation will actively and aggressively be investigated. ResCare</p>						

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W 0153 Bldg. 00	<p>Incident Management and Investigation procedures are to be followed...."</p> <p>The facility failed to ensure facility staff reported all allegations of abuse, neglect and/or exploitation immediately to the administrator and/or to state officials in regard to client S. Please see W153.</p> <p>The facility failed to conduct thorough investigations in regard to allegations of staff to client sexual abuse and/or allegations in regard to exploiting clients L and S. Please see W154.</p> <p>This federal tag relates to complaint #IN00181507.</p> <p>5-1.2(24)(1)</p>			W 0153			10/24/2015
	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on interview and record review for 3 of 4 allegations of abuse, the facility failed to ensure facility staff immediately reported any concerns/allegations of abuse/exploitation to the administrator timely. The facility failed to report an allegation of staff to client exploitation to</p>				<p>The facility ensures that all allegations of mistreatment, neglect and abuse as well as injuries of unknown origin are reported immediately to the administrator or to other officials in accordance with State law. All staff were retrained on policy and procedure regarding reporting</p>		

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	<p>state officials (Bureau of Developmental Disabilities-BDDDS) and/or to Adult Protective Services (APS) for client S.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 9/15/15 at 3:40 PM. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive):</p> <p>-8/30/15 "On August 30, 2015 allegation was made that staff member, [Residential Manager-RM #1], Residential Manager has been having an inappropriate relationship with [client S]. The allegations were reported to another staff member by [client S]. He reported that he and [RM #1] have kissed and held hands and that the relationship has gone on for approximately one month...."</p> <p>The facility's 8/30/15 Investigative Summary indicated "[Direct Support Professional-DSP #1] reports that approximately 2 and half weeks ago, She (sic) came in early to help cover a call off on second shift. She (DSP #1) states that [RM #1] was [client S] 1:1 staff (one staff to one client) staff. She states that she was assigned [client S] and relieved [RM #1]. [DSP #1] reports that as [RM</p>				<p>abuse, neglect and exploitation. All staff were retrained on policy and procedure regarding Professional Boundaries. This training occurred on 10/6/2015. This includes, but is not limited to, immediate reporting requirements for any allegation of abuse, neglect and exploitation of the clients that are served, and ResCare policy requirements for Professional Boundaries between clients and employees. The ResCare Quality Assurance Manager, was retrained on Policy and Procedure requirements for conducting complete and thorough investigations. This includes, but is not limited to ensuring that all clients are interviewed within the scope of any given investigation, and as it is appropriate and necessary to do so. Interviewing all staff that involved with an issue, or as it is necessary to provide a global overview of an incident to ensure that an investigation is complete. All staff names and statements, that were interviewed and as appropriate, will be included in the investigative summary report. In addition retraining included ensuring that all allegations are reported to BDDDS and to APS.***Please note that it may not be necessary to interview every single client, or every single staff person depending on the nature of the allegation or the investigation. When it is necessary, all clients and staff will</p>		

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	<p>#1] was leaving [client S's] room, she (RM #1) told him she would see him later and that [client S] winked at [RM #1] as she left. [DSP #1] states that after [RM #1] left the room, [client S] stated that he could trust her (DSP #1) and wanted to tell her something. [Client S] then proceeded to confide in her that he had a girlfriend on staff. He told her (DSP #1) that he had kissed and french kissed the staff member he referred to as T-Baby. [DSP #1] states that [client S] told he (sic) that T-Baby was [RM #1] and that [client S] understood that staff could get in big trouble for having that type of a relationship with him...[DSP #1] reports that she never mentioned this conversation to anyone. She states that [client S] made veiled threats to her, telling her he would get even if she ever told anyone. [DSP #1] states that [RM #2], RM, her direct supervisor, had mentioned to her that [client S] had stated that he had a girlfriend on staff over the past weekend. She states that she was afraid someone would be falsely accused, so she decided to report what [client S] had confided in her. [DSP #1] further reported that not only was she afraid of [client S], she was afraid that [RM #1], RM, [RM #3], RM and [staff #2] would retaliate against her if she told. [DSP #1] stated that they were all related and that she was afraid that they would allow</p>				<p>be interviewed for complete investigative purposes. ResCare Administration will conduct active treatment observations, at least three times per week, ensuring that an observation is completed at least one time per each shift. This is to ensure that staff are interacting appropriately with clients, that staff understand the professional boundaries necessary to appropriately do their jobs, as well as always observing for ongoing active treatment. In addition, active treatment observations will be utilized as opportunities to provide immediate feedback and retraining for staff working with the clients, at the time of the observation. Observations will be documented on the active treatment observation form. ResCare administrative staff will conduct a weekly peer review/debriefing meeting to determine any training and follow up that will be needed. These observations and debriefings will occur on an ongoing basis. All investigations will be submitted to the Executive Director for review. Investigations will be reviewed for completion, accuracy and thoroughness, per regulation and policy. Date of completion: 10/24/2015 Persons Responsible: Executive Director, Program Manager, QIDP's, Quality Assurance, Nursing Manager</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	<p>[client S] to physically harm her if she told what [client S] had told her...."</p> <p>The facility's 8/30/15 investigation indicated RM #1 was interviewed. RM #1's undated witness summary indicated "[RM #1] denied having an inappropriate relationship with [client S]. She reports that before she was promoted to Resident Manager she had been [client S's] 1:1 staff maybe 9 or 10 times. She states that since her promotion she has never assigned herself to be his 1:1 staff. She stated that she has only been with [client S] while her staff took breaks and never for more than 15 minutes. [RM #1] was presented with [client S's] 5 minute check logs and agreed that she had logged in as his 1:1 staff on many occasions sometimes for several hours at a time, since being resident manager. [RM #1] stated that [client S] had sent her text messages to her personal cell phone. She reported that she had deleted that (sic) text messages but that she could get them from her cell service provider and would turn them in. As of the writing of this report, [RM #1] has failed to present the print out of the text messages she received from [client S]. [RM #1] reports she received the text messages in mid August and that she received texts from him on 9 or 10 different occasions. She states that the messages were</p>						

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	<p>inappropriate in nature; that he missed her, asked her when she was coming in and told her he hoped she was having a nice day...She states that she had not reported the text messages to anyone. [RM #1] further stated that she was aware [client S] had an employee phone list, had ghost money that was not reported on his financials, had the code to the gate and was texting other staff as well and she failed to report all of these things because she did not want [client S] to get into trouble...."</p> <p>The facility's 8/30/15 reportable incident report indicated DSP #3 reported client S told her he was "...talking to someone' she states that she questioned him but that he would not tell her who this person was but she felt he was referring to a staff member...and that he (client S) pays close attention to [RM #1], making certain he speaks to her when she arrives. She (DSP #3) states that [client S] has a close relationship with [RM #1], RM and [DSP #4], stating it is not professional but like 'they are buds.' She states that she immediately reported this information to her direct supervisor, [RM #3], Resident Manager...."</p> <p>The facility's 8/30/15 investigation indicated RM #3 was interviewed. RM #3's undated summary indicated "[RM</p>						

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	<p>#3] reports that [client S] had told him on several occasions in the past two weeks that he has a girl on staff he is 'talking to.' [RM #3] states that [client S] told him they were going to hook up when he is released and that he has to be good so he can get (sic) of here. [RM #3] states that he thought that [client S] was blowing smoke and that he played it off. [RM #3] states that he did not report this information. [RM #3] further states that [DSP #3] had reported to him that [client S] had told her he was seeing a staff member but that he did not report this information to his supervisor."</p> <p>The facility's 8/30/15 investigation indicated DSP #5 was interviewed. DSP #5's undated summary indicated he had worked as client S's 1:1 staff when he (DSP #5) saw client S texting from his tablet computer. DSP #5's summary indicated he saw staff's names on the client's computer. DSP #5's summary indicated "...[client S] also confided in him that he has what he calls ghost money. [DSP #5] explains that [client S] confided in him that ghost money is cash that he gets from staff as gifts or for payment for burning music CDs or downloading movies for staff onto portable drives, that is not recorded on his financials. [DSP #5] states [client S] did not tell him what staff had given him</p>						

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	<p>ghost money. [DSP #5] states that [client S] told him he had the code to the back security gate off the gym. [Client S] did not tell him how he got the code. [DSP #5] reports that [client S] had never said anything to him regarding a girlfriend but that when he reported to his direct supervisor, [RM #3], RM on Thursday (sic) regarding the texting, the gate code and the ghost money, that [RM #3] told him he (RM #3) suspected that [RM #1], RM was [client S's] girlfriend. [DSP #5] further reports that after reporting this information to [RM #3], he was concerned that [RM #3] had not followed up so he reported to [RM #4], RM the following day."</p> <p>The facility's 8/30/15 investigation indicated DSP #6 was interviewed in regard to the allegation of abuse. DSP #6's witness statement indicated client S had told DSP #6 about the "ghost money." DSP #6's summary indicated "...She (DSP #6) describes it as money he gets from staff for burning music CD's...She (DSP #6) further states that [client S] has told her that [RM #5], RM and [DSP #2], DSP have promised to give him an automobile when he is released from ResCare. [DSP #6] states that she (sic) [client S] has what she referred to as a crush on [RM #1]...." DSP #6's summary indicated the staff</p>						

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	<p>knew about client S having the code to the gate. The staff's summary also indicated "...she heard [RM #1] on the phone in the employee break room on Saturday and had stated that she needed to remove something from [client S's] room before it was found. [DSP #6] reports that she thought she (RM #1) was speaking to [RM #5] on the phone, because she could hear [RM #5's] voice on (sic) through the phone...." The DSP's summary indicated she did not report client S's having the code to the gate to her supervisor.</p> <p>The facility's 8/30/15 summary indicated DSP #7 was interviewed. DSP #7's summary indicated client S had told the staff person about his "ghost money" from where client S made music CDs for staff. DSP #7's witness statement indicated DSP #7 had bought the client a pop on one occasion when they were at the county fair. DSP #7's summary indicated she did not purchase any CDs from client S. DSP #7's summary also indicated client S was with RM #1 "a lot." The summary indicated "...[DSP #7] states that she had witnessed [RM #1] dancing for [client S]. She (DSP #7) reports that she walked into [client S's] room and that he was video recording [RM #1] dancing on his tablet. She states that when [RM #1] saw her, she was very</p>						

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	<p>surprised and told [client S] that he must erase the video. [DSP #7] states that she did not report this to anyone."</p> <p>-"On 9/1/15 at approximately 9:37 pm it was alleged that [client S] reported to RM [RM #5] that DSP [DSP #3] had performed oral sex on him. DSP [DSP #7] told her peer. DSP [DSP #3] was immediately suspended pending the outcome of the investigation. Though (sic) the course of the investigation [RM #5] denies an allegation was made. [Client S] denies any allegation of sexual abuse and any allegation was ever made. The outcome of the investigation is unsubstantiated."</p> <p>The facility's 9/1/15 Investigation Summary indicated "[RM #6] reports that he was approached by [DSP #8], DSP, who reported to him that [DSP #7], DSP had told her that DSP [DSP #3] had 'given [client S] head.' [RM #6] clarified that [DSP #8] was referring to oral sex. [RM #6] stated that he spoke to [DSP #7] and that she reported to him that RM [RM #5] had informed her of this earlier in the evening."</p> <p>The facility's 9/1/15 investigation indicated DSP #9 was interviewed in regard to the allegation of sexual abuse. DSP #9's undated witness summary</p>						

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	<p>indicated DSP #7 had told her about DSP #7 questioning client S about a girlfriend he had on the second shift. DSP #9's statement indicated DSP #7 also told DSP #9 client S had stated he and RM #1 "had only kissed." The 9/1/15 investigation indicated "...[DSP #9] states that [DSP #7] continued to question [client S] about [DSP #3]. [DSP #7] reported to [DSP #9] that he [client S] only grinned when she mentioned [DSP #3]."</p> <p>The facility's 9/1/15 investigation indicated RM #5 denied knowing anything about the allegation of sexual abuse against DSP #3. RM #5's undated witness summary indicated "...When questioned regarding the conversation she had with [DSP #7] she stated that she had heard something about [client S] and [DSP #3] but could not remember who told her. When asked who she had discussed the investigation with, she (RM #5) replied that she had only spoken to [DSP #7] about it. When questioned if she had discussed the matter with [client S], she stated that she had spoke (sic) to him...She said that [client S] had told her that he feels like staff is going to be hurt and its his fault. She then stated that [client S] had been talking to her regarding [RM #1] and getting candy and soda from staff that they were speaking in</p>						

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	<p>hypotheticals...."</p> <p>-8/30/15 investigation indicated "During the course of an abuse investigation, allegation regarding policy violations were made, including but not limited to; (sic) staff providing muscle relaxers to consumers, staff making purchases of pirated music and movies from consumers, staff bringing in candy, sugary soft drinks and energy drinks for consumers, staff and consumers texting one another on personal cell phones, consumers selling electronics to staff, staff furnishing consumers with electronic devices and staff failing to report policy violations." Review of the facility's reportable incident reports from 8/1/15 to the present indicated the facility did not report the above mentioned 8/30/15 allegation of staff to client abuse, mistreatment and/or exploitation to BDDS and to APS.</p> <p>Interview with administrative staff #1, the Program Manager (PM), the Qualified Intellectual Disabilities Professional (QIDP) and Quality Assurance (QA) staff #1 on 9/16/15 at 1:09 PM and at 1:55 PM indicated client S no longer lived at the facility. Administrative staff #1 and the QA staff indicated facility staff and the RMs did not immediately report their concerns in</p>						

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W 0154 Bldg. 00	<p>regard to RM #1's relationship with client S, exploitation of the client and/or their concerns regarding the client knowing the codes to the gate. QA staff #1 and the administrative staff #1 indicated the facility reported the 9/1/15 allegations of staff to client abuse/exploitation to state officials. QA staff #1 and/or administrative staff #1 did not provide any additional documentation in regard to the 9/1/15 allegation of exploitation/abuse being reported to BDDS and/or APS.</p> <p>This federal tag relates to complaint #IN00181507.</p> <p>5-1.3(h)(1)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 3 of 4 allegations of abuse, neglect and/or exploitation reviewed, the facility failed to conduct a thorough investigation in regard to the allegations of staff to client abuse and/or exploitation of clients L and S.</p> <p>Findings include:</p>			W 0154	<p>The facility ensures that all necessary evidence exists that all alleged violations are thoroughly investigated. All staff were retrained on policy and procedure regarding reporting abuse, neglect and exploitation. All staff were retrained on policy and procedure regarding Professional Boundaries. (see attached) This training occurred on 10/6/2015. This includes, but is not limited to, immediate reporting requirements</p>		10/24/2015

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	<p>1. The facility's reportable incident reports and/or investigations were reviewed on 9/15/15 at 3:40 PM. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive):</p> <p>-8/30/15 "On August 30, 2015 allegation was made that staff member, [Residential Manager-RM #1], Residential Manager has been having an inappropriate relationship with [client S]. The allegations were reported to another staff member by [client S]. He reported that he and [RM #1] have kissed and held hands and that the relationship has gone on for approximately one month...." The 8/30/15 reportable incident report indicated RM #1 was suspended pending an investigation.</p> <p>The facility's 9/9/15 follow-up report to the 8/30/15 reportable incident report indicated "...Investigation was unsubstantiated."</p> <p>The facility's 8/30/15 Investigative Summary indicated "[Direct Support Professional-DSP #1] reports that approximately 2 and half weeks ago, She (sic) came in early to help cover a call off on second shift. She (DSP #1) states that [RM #1] was [client S] 1:1 staff (one staff to one client) staff. She states that</p>			<p>for any allegation of abuse, neglect and exploitation of the clients that are served, and ResCare policy requirements for Professional Boundaries between clients and employees. The ResCare Quality Assurance Manager, was retrained on Policy and Procedure requirements for conducting complete and thorough investigations. (see attached) This includes, but is not limited to ensuring that all clients are interviewed within the scope of any given investigation, and as it is appropriate and necessary to do so. Interviewing all staff that involved with an issue, or as it is necessary to provide a global overview of an incident to ensure that an investigation is complete. All staff names and statements, that were interviewed and as appropriate, will be included in the investigative summary report. In addition retraining included ensuring that all allegations are reported to BDDS and to APS. ***Please note that it may not be necessary to interview every single client, or every single staff person depending on the nature of the allegation or the investigation. When it is necessary, all clients and staff will be interviewed for complete investigative purposes. ResCare Administration will conduct active treatment observations, at least three times per week, ensuring that an observation is completed at least one time per each shift.</p>			

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	<p>she was assigned [client S] and relieved [RM #1]. [DSP #1] reports that as [RM #1] was leaving [client S's] room, she (RM #1) told him she would see him later and that [client S] winked at [RM #1] as she left. [DSP #1] states that after [RM #1] left the room, [client S] stated that he could trust her (DSP #1) and wanted to tell her something. [Client S] then proceeded to confide in her that he had a girlfriend on staff. He told her (DSP #1) that he had kissed and french kissed the staff member he referred to as T-Baby. [DSP #1] states that [client S] told he (sic) that T-Baby was [RM #1] and that [client S] understood that staff could get in big trouble for having that type of a relationship with him...[DSP #1] reports that she never mentioned this conversation to anyone. She states that [client S] made veiled threats to her, telling her he would get even if she ever told anyone. [DSP #1] states that [RM #2], RM, her direct supervisor, had mentioned to her that [client S] had stated that he had a girlfriend on staff over the past weekend. She states that she was afraid someone would be falsely accused, so she decided to report what [client S] had confided in her. [DSP #1] further reported that not only was she afraid of [client S], she was afraid that [RM #1], RM, [RM #3], RM and [staff #2] would retaliate against her if she told. [DSP #1]</p>				<p>This is to ensure that staff are interacting appropriately with clients, that staff understand the professional boundaries necessary to appropriately do their jobs, as well as always observing for ongoing active treatment. In addition, active treatment observations will be utilized as opportunities to provide immediate feedback and retraining for staff working with the clients, at the time of the observation. Observations will be documented on the active treatment observation form. ResCare administrative staff will conduct a weekly peer review/debriefing meeting to determine any training and follow up that will be needed. These observations and debriefings will occur on an ongoing basis. All investigations will be submitted to the Executive Director for review. Investigations will be reviewed for completion, accuracy and thoroughness, per regulation and policy. Date of completion: 10/24/2015 Persons Responsible: Executive Director, Program Manager, QIDP's, Quality Assurance, Nursing Manager</p>		

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	<p>stated that they were all related and that she was afraid that they would allow [client S] to physically harm her if she told what [client S] had told her...."</p> <p>The facility's 8/30/15 investigation indicated RM #1 was interviewed. RM #1's undated witness summary indicated "[RM #1] denied having an inappropriate relationship with [client S]. She reports that before she was promoted to Resident Manager she had been [client S's] 1:1 staff maybe 9 or 10 times. She states that since her promotion she has never assigned herself to be his 1:1 staff. She stated that she has only been with [client S] while her staff took breaks and never for more than 15 minutes. [RM #1] was presented with [client S's] 5 minute check logs and agreed that she had logged in as his 1:1 staff on many occasions sometimes for several hours at a time, since being resident manager. [RM #1] stated that [client S] had sent her text messages to her personal cell phone. She reported that she had deleted that (sic) text messages but that she could get them from her cell service provider and would turn them in. As of the writing of this report, [RM #1] has failed to present the print out of the text messages she received from [client S]. [RM #1] reports she received the text messages in mid August and that she received texts</p>						

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	<p>from him on 9 or 10 different occasions. She states that the messages were inappropriate in nature; that he missed her, asked her when she was coming in and told her he hoped she was having a nice day...She states that she had not reported the text messages to anyone. [RM #1] further stated that she was aware [client S] had an employee phone list, had ghost money that was not reported on his financials, had the code to the gate and was texting other staff as well and she failed to report all of these things because she did not want [client S] to get into trouble...."</p> <p>The facility's 8/30/15 reportable incident report indicated DSP #3 reported client S told her he was "...talking to someone' she states that she questioned him but that he would not tell her who this person was but she felt he was referring to a staff member...and that he (client S) pays close attention to [RM #1],making certain he speaks to her when she arrives. She (DSP #3) states that [client S] has a close relationship with [RM #1], RM and [DSP #4], stating it is not professional but like 'they are buds'...."</p> <p>The facility's 8/30/15 investigation indicated RM #3 was interviewed. RM #3's undated summary indicated "[RM #3] reports that [client S] had told him on</p>						

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	<p>several occasions in the past two weeks that he has a girl on staff he is 'talking to.' [RM #3] states that [client S] told him they were going to hook up when he is released and that he has to be good so he can get (sic) of here...."</p> <p>The facility's 8/30/15 investigation indicated DSP #5 was interviewed. DSP #5's undated summary indicated he had worked as client S's 1:1 staff when he (DSP #5) saw client S texting from his tablet computer. DSP #5's summary indicated he saw staff's names on the client's computer. DSP #5's summary indicated "...[client S] also confided in him that he has what he calls ghost money. [DSP #5] explains that [client S] confided in him that ghost money is cash that he gets from staff as gifts or for payment for burning music CDs or downloading movies for staff onto portable drives, that is not recorded on his financials. [DSP #5] states [client S] did not tell him what staff had given him ghost money. [DSP #5] states that [client S] told him he had the code to the back security gate off the gym. [Client S] did not tell him how he got the code...."</p> <p>The facility's 8/30/15 investigation indicated DSP #6 was interviewed in regard to the allegation of abuse. DSP #6's witness statement indicated client S</p>						

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	<p>had told DSP #6 about the "ghost money." DSP #6's summary indicated "...She (DSP #6) describes it as money he gets from staff for burning music CD's...She (DSP #6) further states that [client S] has told her that [RM #5], RM and [DSP #2], DSP have promised to give him an automobile when he is released from ResCare. [DSP #6] states that she (sic) [client S] has what she referred to as a crush on [RM #1]...." DSP #6's summary indicated the staff knew about client S having the code to the gate. The staff's summary also indicated "...she heard [RM #1] on the phone in the employee break room on Saturday and had stated that she needed to remove something from [client S's] room before it was found. [DSP #6] reports that she thought she (RM #1) was speaking to [RM #5] on the phone, because she could hear [RM #5's] voice on (sic) through the phone...."</p> <p>The facility's 8/30/15 summary indicated DSP #7 was interviewed. DSP #7's summary indicated client S had told the staff person about his "ghost money" from where client S made music CDs for staff. DSP #7's witness statement indicated DSP #7 had bought the client a pop on one occasion when they were at the county fair. DSP #7's summary indicated she did not purchase any CDs</p>						

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	<p>from client S. DSP #7's summary also indicated client S was with RM #1 "a lot." The summary indicated "...[DSP #7] states that she had witnessed [RM #1] dancing for [client S]. She (DSP #7) reports that she walked into [client S's] room and that he was video recording [RM #1] dancing on his tablet. She states that when [RM #1] saw her, she was very surprised and told [client S] that he must erase the video. [DSP #7] states that she did not report this to anyone." The facility's 8/30/15 investigation indicated the following:</p> <p>"Factual Findings: The allegations of sexual abuse are unsubstantiated as both [RM #1] and [client S] deny allegations. It is evident that [RM #1], RM, has violated ResCare policy in that she had direct knowledge that [client S] was texting staff including herself, that [client S] had the security access code to the back gate and that he was in possession of what he referred to as ghost money, that was not recorded on his financial records.</p> <p>Conclusion: It is determined that [RM #1] has violated ResCare policy in that she had direct knowledge that [client S] was non compliant with his Individual Support Plan as well as his Behavioral Support Plan, that she has failed to report this non compliance and has undermined</p>						

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	<p>his program." The facility's 8/30/15 investigation indicated the facility failed to interview all clients at the facility in regard to "ghost money" and/or to see if any other clients were being exploited by facility staff and/or abused. The facility's 8/30/15 investigation indicated the facility did not include client S's witness statement and/or summary, did not interview all staff who worked at the facility to determine who participated in the exploitation of client S and/or knew about client S's and RM #1's relationship. The facility's 8/30/15 investigation did not indicate DSP #2 was interviewed in regard to her involvement and/or indicate RM #5 was interviewed in regard to her involvement of the exploitation of client S. The facility's 8/30/15 investigation did not indicate any recommendations in regard to DSPs and/or RMs not reporting allegations of abuse and/or exploitation to the administrator immediately.</p> <p>- "On 9/1/15 at approximately 9:37 pm it was alleged that [client S] reported to RM [RM #5] that DSP [DSP #3] had performed oral sex on him. DSP [DSP #7] told her peer. DSP [DSP #3] was immediately suspended pending the outcome of the investigation. Though (sic) the course of the investigation [RM #5] denies an allegation was made. [Client S] denies any allegation of sexual</p>						

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	<p>abuse and any allegation was ever made. The outcome of the investigation is unsubstantiated."</p> <p>The facility's 9/1/15 Investigation Summary indicated "[RM #6] reports that he was approached by [DSP #8], DSP, who reported to him that [DSP #7], DSP had told her that DSP [DSP #3] had 'given [client S] head.' [RM #6] clarified that [DSP #8] was referring to oral sex. [RM #6] stated that he spoke to [DSP #7] and that she reported to him that RM [RM #5] had informed her of this earlier in the evening."</p> <p>The facility's 9/1/15 investigation indicated DSP #9 was interviewed in regard to the allegation of sexual abuse. DSP #9's undated witness summary indicated DSP #7 had told her about DSP #7 questioning client S about a girlfriend he had on the second shift. DSP #9's statement indicated DSP #7 also told DSP #9 client S had stated he and RM #1 "had only kissed." The 9/1/15 investigation indicated "...[DSP #9] states that [DSP #7] continued to question [client S] about [DSP #3]. [DSP #7] reported to [DSP #9] that he [client S] only grinned when she mentioned [DSP #3]."</p> <p>The facility's 9/1/15 investigation</p>						

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	<p>indicated RM #5 denied knowing anything about the allegation of sexual abuse against DSP #3. RM #5's undated witness summary indicated "...When questioned regarding the conversation she had with [DSP #7] she stated that she had heard something about [client S] and [DSP #3] but could not remember who told her. When asked who she had discussed the investigation with, she (RM #5) replied that she had only spoken to [DSP #7] about it. When questioned if she had discussed the matter with [client S], she stated that she had spoke (sic) to him...She said that [client S] had told her that he feels like staff is going to be hurt and its his fault. She then stated that [client S] had been talking to her regarding [RM #1] and getting candy and soda from staff that they were speaking in hypotheticals...." RM #5's witness statement indicated client S did not make an allegation of abuse against DSP #3 and/or RM #1. The facility's investigation indicated "...[RM #5] reports that she understands ResCare policy regarding cooperating with investigations and that her actions in speaking with [client S] and [DSP #7] were a direct violation of policy. [DSP #3], DSP denies having any sexual contact with [client S]. Factual Findings: The allegations of sexual abuse are unsubstantiated. Conclusion: It is</p>						

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	<p>determined through interviews with staff and [client S] that sexual abuse did (sic) not occur. The allegations were made as a direct result of [RM #5's] RM, and [DSP #7's], DSP violating Res Care policy regarding cooperating with the investigation process." The facility's 9/1/15 investigation indicated the facility did not include/indicate client S's interview, and/or did not indicate other clients who lived at the facility were interviewed in regard to staff to client sexual abuse. The facility's investigation indicated the facility's investigation did not include the witness summary from staff DSP #3.</p> <p>-8/30/15 investigation indicated "During the course of an abuse investigation, allegations regarding policy violations were made, including but not limited to; staff providing muscle relaxers to consumers, staff making purchases of pirated music and movies from consumers, staff bringing in candy, sugary soft drinks and energy drinks for consumers, staff and consumers texting one another on personal cell phones, consumers selling electronics to staff, staff furnishing consumers with electronic devices and staff failing to report policy violations."</p> <p>The facility's 8/30/15 investigation</p>						

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	<p>indicated DSP #2 was interviewed. DSP #2's undated witness summary indicated "[DSP #2] denies having any knowledge of consumers having possessions of contraband. She states that she several months ago she (sic) gave [client N] a mountain dew...[DSP #2] reported that she had spoken to [client S] regarding a tablet computer in his possession. She states that she asked [client S] where the tablet came from and he told her it was a tablet he brought with him from [name of facility] and that he had removed the case...[DSP #2] stated that [RM #5] first told her about pills being found in [client S's] possession. [DSP #2] was later questioned on (sic) reported at that time that she had brought a new tablet to [client S], she stated that she was paying for the tablet on her [name of company] cellular account. [DSP #2] reported that she had not removed that tablet from campus and has no idea where the tablet is now." The facility's investigation also indicated DSP #10 had brought client S a candy bar "a month ago."</p> <p>The facility's 8/30/15 investigation indicated DSP #7 admitted to buying client S a pop while on an outing. The facility's investigation indicated "...[DSP #7] reports that [client S] had offered to burn a music CD for her but that she refused to accept. She states that [client</p>						

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	<p>S] had told her about ghost money...[DSP #7] reports that she did not report this to her supervisor and...[DSP #7] states that she had seen [client S] with a new tablet computer and that she asked him about it. He told her that he had removed the case from the tablet he brought with him from [name of facility]. [DSP #7] reports that she knew it was not the same but reports that she did not report this either...." The facility's 8/30/15 investigation indicated DSP #7 knew client S had the code to the gate, and saw RM #1 dancing while client S video taped RM #1.</p> <p>The facility's 8/30/15 investigation indicated RM #3 admitted not reporting seeing client S with a sugary drink in his bedroom, and did not report he knew client S had the code to the back gate. The facility's investigation indicated RM #3 admitted he did not report client S's telling him he had a girlfriend he was talking to and they had planned to "hook up" when he left the facility. The facility's 8/30/15 investigation indicated RM #3 had admitted to knowing client S was texting staff and knew the back gate code. The facility's investigation also indicated RM #3 was aware "...that a consumer had been trafficking (staff doing favors and/or paying the client for CDs and/or movies) with staff..." The facility's 8/30/15 investigation indicated</p>						

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	<p>"...It is determined through evidence and interviews that [DSP #2], [DSP #10], [DSP #7], RM #3, [DSP #1], [RM #1] and [RM #5] have all violated ResCare policy in that they failed to follow Individual Support Plans, Behavior Support Plans and failed to report either allegations of policy violations to their immediate supervisors or administration. Conclusion: It is recommended that the above mentioned personal (sic) be terminated from employment for policy violations."</p> <p>Client S's 5 minute checks (one on one staffing logs) were reviewed on 9/15/15 at 12:35 PM. Client S's 5 minute checks indicated RM #1 was client S's 1:1 staff on the following dates/times:</p> <p>-8/4/15 4:00 PM to 9:00 PM and 10:50 PM to 11:10 PM. -8/6/15 4:00 PM to 10:10 PM and from 10:35 PM to 11:45 PM. -8/9/15 3:55 PM to 7:40 PM, 8:05 PM to 9:55 PM and from 10:10 PM to 11:55 PM. -8/10/15 10:35 PM to 11:55 PM. -8/12/15 4:10 PM to 7:55 PM and from 8:15 PM to 11:10 PM. -8/16/15 8:50 PM to 9:40 PM and from 10:10 PM to 10:25 PM. -8/17/15 8:45 PM to 10:10 PM and from 10:15 PM to 10:30 PM.</p>						

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	<p>-8/22/15 5:10 PM to 7:00 PM. -8/23/15 9:50 PM to 10:05 PM. -8/27/15 5:05 PM to 6:20 PM and from 9:20 PM to 9:40 PM. -8/28/15 5:45 PM to 6:15 PM.</p> <p>RM #1's personnel record was reviewed on 9/16/15 at 12:10 PM. RM #1's personnel record indicated the RM was terminated from her employment with ResCare on 9/14/15. The facility's 9/14/15 Corrective Action Form indicated RM #1 was aware of a client having access to a gate code, and failed to report allegations of abuse/neglect to her supervisor and/or management staff.</p> <p>The facility's inservice training records were reviewed on 9/16/15 at 12:10 PM. The facility's 9/8/15 Inservice Sign-in Sheet indicated all facility staff were retrained in regard to reporting abuse/neglect and policy violations and "Professional Boundaries."</p> <p>Client S's record was reviewed on 9/16/15 at 1:05 PM. Client S's 7/21/15 Interdisciplinary Team (IDT) Meeting note indicated "[Client S] has made progress working with his 1:1 staffing while on campus to stay busy and positive. He has not targeted any female staff to date...Recommendations: The IDT agrees that [client S's] 1:1 staff does</p>						

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	<p>not have to be a male staff on campus. When in the community [client S] is still 2:1 staffing, one of his staff must be male due to a history of bolting, and one of his staff may drive...."</p> <p>Client S's 9/8/15 IDT note indicated "On September 8, 2015 [client S] expressed to his IDT that he would like to leave services today...By signing himself out today [client S] understands that ResCare will no longer have responsibility for his care or supervision. [Client S] expressed that he would like to go to either [name of shelter and address] in [name of city] or [name of shelter and address] in [name of city]. ResCare Administration has agreed to assist with his transport...."</p> <p>Interview with client E on 9/15/15 at 6:55 PM indicated clients were not allowed to date facility staff. Client E indicated he would report staff if they asked him to do a favor for money. When asked what ghost money was, client E stated "I don't know what it is." Client E indicated clients were not allowed to have or know the codes to the gate.</p> <p>Interview with client K on 9/16/15 at 9:22 AM indicated he did not know what ghost money was. When asked if a client was allowed to date a staff person, client K stated "No." Client K indicated he had</p>						

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	<p>not received any money from staff in regard to doing favors.</p> <p>Interview with client J on 9/16/15 at 9:32 AM indicated facility staff had not asked the client to do a favor for them in exchange for money. When asked what ghost money was client J stated "When staff gives you money out of their pocket." Client J was not able to provide any additional information as the client indicated his money was kept in the filing cabinet in the closet.</p> <p>Interview with DSP #12 on 9/16/15 at 9:39 AM indicated he had heard the phrase ghost money but did not know what it was. DSP #12 indicated he had been interviewed by facility's administrative staff in regard to an allegation of staff to client sexual abuse. DSP #12 indicated he had not witnessed staff being too friendly with clients.</p> <p>Interview with DSP #11 on 9/16/15 at 9:49 AM indicated he was not aware of any staff going with a client. DSP #11 indicated it was against the facility's policy for a staff to date a client. DSP #11 indicated client S used to have male 1:1 staffing but it had changed recently.</p> <p>Interview with DSP #5 on 9/16/15 at 10:00 AM indicated clients were not</p>						

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	<p>allowed to date staff. DSP #5 indicated clients were not allowed to have the codes to the gate. When asked what ghost money was, DSP #5 stated "[Client S] was selling burned CDs to get money that was not tracked." DSP #5 stated he had "Not witnessed" this occurring. When asked if DSP #5 was aware of staff being too friendly with clients, DSP #5 stated "Just rumors and that was reported."</p> <p>Interview with RM #3 on 9/16/15 at 10:16 AM indicated clients were not to have codes to the gate. RM #3 indicated he was aware client S had the code to the gate and the code was changed. RM #3 indicated facility staff were not allowed to date clients per the facility's policy. When asked if RM #3 was aware of staff dating a client, RM #3 stated "Not until the investigation took place." When asked what ghost money was, RM #3 stated "No idea." When asked if he had been made aware of any incidents where staff were too friendly with clients, RM #3 stated "Never been made aware of it or seen it." RM #3 indicated he was aware an allegation had been made against a staff person.</p> <p>Interview with administrative staff #1, the Program Manager (PM), the Qualified Intellectual Disabilities</p>						

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	Professional (QIDP) and Quality Assurance (QA) staff #1 on 9/16/15 at 1:09 PM and at 1:55 PM indicated client S no longer lived at the facility. Administrative staff #1 and the QA staff #1 indicated the facility interviewed all staff at the facility. QA staff #1 indicated she did not include all the interviews in her investigation of the staff to client sexual abuse and/or exploitation. QA staff #1 also indicated client S was interviewed but his statement was not part of the 8/30/15 investigations. QA staff #1 and administrative staff #1 indicated no other clients were interviewed in regard to the allegations of staff to client sexual abuse and/or exploitation. Administrative staff #1 indicated the facility's investigation should have included all staff interviews. Administrative staff #1 indicated more investigations were started as a result of additional allegations made during the investigation. The PM, administrative staff #1 and QA staff #1 indicated client S was texting facility staff from a computer tablet which was given to the client. Administrative staff indicated the client was taking orders for burning CDs and downloading movies from staff which the facility staff were paying the client. Administrative staff #1 indicated the money client S made was not being documented on the client's financial log.						

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	<p>Administrative staff #1 and the QA staff indicated they did not know how client S received the codes. The QIDP, PM, administrative staff #1 and the QA staff stated client S's functioning level was "very high." Administrative staff #1 stated client S was able to "manipulate staff to get what he wanted." QA staff #1 and administrative staff #1 stated the facility was not able to "prove sexual abuse" between RM #1 and client S. Administrative staff #1 indicated 4 staff had been terminated in regard to the 8/30/15 and 9/1/15 allegations of staff to client abuse within the last 24 hours. Administrative staff #1 indicated 3 RMs had been terminated and 1 DSP. Administrative staff indicated corrective action was going to be taken with RM #3. Administrative staff #1 stated RM #3 was going to be placed on "Final action." QA staff #1 and administrative staff #1 indicated facility staff were buying the client pop, candy and computer items. QA staff #1 indicated client S admitted he was getting things from staff but would not identify who had given him things and/or who was purchasing CDs/downloaded movies from him. QA staff #1 indicated they did not conduct an investigation in regard to RM #1 dancing for client S. QA staff #1 indicated client S's 5 minute checks indicated RM #1 was working as client S's one on one staff</p>						

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	<p>person when RM #1 indicated she had not worked as the client's 1:1 staff person.</p> <p>2. The facility reportable incident reports and/or investigations were reviewed on 9/15/15 at 3:40 PM. The facility's 9/1/15 reportable incident report indicated "On 9-01-2015 [client L] requested to take \$2.00 to work with him. When staff checked his financial binder, which listed a balance of \$13.31 cash on hand, they found no money in the binder. A search of the RM (Resident Manager) closet and other client's (sic) financial binders did not discover the funds. An investigation of client funds and financial procedures found that [client L] was missing \$13.31 and staff followed current procedures-all transitions (sic) documented, receipts for spent cash were present. The investigation was unable to establish how the funds came up missing. ResCare has reimbursed [client L] \$13.31. During the all staff meetings for September all staff will be retrained on financial procedures for documenting, and storing client finances."</p> <p>The facility's 9/3/15 Investigative Summary indicated 4 staff and client L were interviewed in regard to client L's missing funds. The facility's investigation indicated the money was</p>						

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	<p>placed in client L's binder after the client's outing. The facility's 9/3/15 investigation indicated "...Conclusion: Staff placed money in [client L's] financial binder on 8-21-2015 and appropriately logged his transactions, which match his receipts. All parties agree to the amount of funds that should have been present but are now missing."</p> <p>Interview with the Program Manager, administrative staff #1 and QA staff #1 on 9/16/15 at 1:55 PM indicated client L had been reimbursed for his missing funds on 9/3/15. The PM indicated the PM and the RMs had access to the clients' funds which were kept in the RMs' closet on the unit. The PM indicated not all RMs were interviewed as the money was present at the start of the shift on 9/1/15 but not at the end of the shift. The PM indicated the staff who worked on 9/1/15, were the only staff interviewed. The PM indicated client L was interviewed and no other client interviews were conducted to see if clients saw anyone go into the RM closet since it was on the unit.</p> <p>This federal tag relates to complaint #IN00181507.</p> <p>5-1.2(o)(4)(A)(E)</p>						

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W 0267 Bldg. 00	<p>483.450(a)(1) CONDUCT TOWARD CLIENT</p> <p>The facility must develop and implement written policies and procedures for the management of conduct between staff and clients.</p> <p>Based on interview and record review for 1 additional client (S), the facility failed to implement its policy and procedures in regard to staff to client conduct to ensure appropriate interactions between staff and clients.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 9/15/15 at 3:40 PM. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive):</p> <p>-8/30/15 "On August 30, 2015 allegation was made that staff member, [Residential Manager-RM #1], Residential Manager has been having an inappropriate relationship with [client S]. The allegations were reported to another staff member by [client S]. He reported that he and [RM #1] have kissed and held hands and that the relationship has gone on for approximately one month...."</p>			W 0267	<p>The facility ensures that written policies exist and are followed regarding the management of conduct between employees and clients. All staff were retrained on policy and procedure regarding reporting abuse, neglect and exploitation. All staff were retrained on policy and procedure regarding Professional Boundaries. (see attached) This training occurred on 10/6/2015. This includes, but is not limited to, immediate reporting requirements for any allegation of abuse, neglect and exploitation of the clients that are served, and ResCare policy requirements for Professional Boundaries between clients and employees. ResCare Administration will conduct active treatment observations, at least three times per week, ensuring that an observation is completed at least one time per each shift. This is to ensure that staff are interacting appropriately with clients, that staff understand the professional boundaries necessary to appropriately do their jobs, as well as always observing for ongoing active treatment. In addition, active treatment observations will be utilized as opportunities to provide immediate feedback and</p>		10/24/2015

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	<p>The facility's 9/9/15 follow-up report to the 8/30/15 reportable incident report indicated "...Investigation was unsubstantiated."</p> <p>The facility's 8/30/15 Investigative Summary indicated "[Direct Support Professional-DSP #1] reports that approximately 2 and half weeks ago, She (sic) came in early to help cover a call off on second shift. She (DSP #1) states that [RM #1] was [client S] 1:1 staff (one staff to one client) staff. She states that she was assigned [client S] and relieved [RM #1]. [DSP #1] reports that as [RM #1] was leaving [client S's] room, she (RM #1) told him she would see him later and that [client S] winked at [RM #1] as she left. [DSP #1] states that after [RM #1] left the room, [client S] stated that he could trust her (DSP #1) and wanted to tell her something. [Client S] then proceeded to confide in her that he had a girlfriend on staff. He told her (DSP #1) that he had kissed and french kissed the staff member he referred to as T-Baby. [DSP #1] states that [client S] told he (sic) that T-Baby was [RM #1] and that [client S] understood that staff could get in big trouble for having that type of a relationship with him.... "</p> <p>The facility's 8/30/15 investigation</p>				<p>retraining for staff working with the clients, at the time of the observation. Observations will be documented on the active treatment observation form. ResCare administrative staff will conduct a weekly peer review/debriefing meeting to determine any training and follow up that will be needed. These observations and debriefings will occur on an ongoing basis. All investigations will be submitted to the Executive Director for review. Investigations will be reviewed for completion, accuracy and thoroughness, per regulation and policy. Date of completion: 10/24/2015 Persons Responsible: Executive Director, Program Manager, QIDP's, Quality Assurance, Nursing Manager</p>		

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	<p>indicated RM #1 was interviewed. RM #1's undated witness summary indicated "[RM #1] denied having an inappropriate relationship with [client S]. She reports that before she was promoted to Resident Manager she had been [client S's] 1:1 staff maybe 9 or 10 times. She states that since her promotion she has never assigned herself to be his 1:1 staff. She stated that she has only been with [client S] while her staff took breaks and never for more than 15 minutes. [RM #1] was presented with [client S's] 5 minute check logs and agreed that she had logged in as his 1:1 staff on many occasions sometimes for several hours at a time, since being resident manager. [RM #1] stated that [client S] had sent her text messages to her personal cell phone. She reported that she had deleted that (sic) text messages but that she could get them from her cell service provider and would turn them in. As of the writing of this report, [RM #1] has failed to present the print out of the text messages she received from [client S]. [RM #1] reports she received the text messages in mid August and that she received texts from him on 9 or 10 different occasions. She states that the messages were inappropriate in nature; that he missed her, asked her when she was coming in and told her he hoped she was having a nice day...She states that she had not</p>						

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	<p>reported the text messages to anyone. [RM #1] further stated that she was aware [client S] had an employee phone list, had ghost money that was not reported on his financials, had the code to the gate and was texting other staff as well.... "</p> <p>The facility's 8/30/15 reportable incident report indicated DSP #3 reported client S told her he was "...talking to someone' she states that she questioned him but that he would not tell her who this person was but she felt he was referring to a staff member...and that he (client S) pays close attention to [RM #1], making certain he speaks to her when she arrives. She (DSP #3) states that [client S] has a close relationship with [RM #1], RM and [DSP #4], stating it is not professional but like 'they are buds ' "</p> <p>The facility's 8/30/15 investigation indicated RM #3 was interviewed. RM #3's undated summary indicated "[RM #3] reports that [client S] had told him on several occasions in the past two weeks that he has a girl on staff he is 'talking to.' [RM #3] states that [client S] told him they were going to hook up when he is released and that he has to be good so he can get (sic) of here.... "</p> <p>The facility's 8/30/15 investigation</p>						

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	<p>indicated DSP #5 was interviewed. DSP #5's undated summary indicated he had worked as client S's 1:1 staff when he (DSP #5) saw client S texting from his tablet computer. DSP #5's summary indicated he saw staff's names on the client's computer. DSP #5's summary indicated "...[client S] also confided in him that he has what he calls ghost money. [DSP #5] explains that [client S] confided in him that ghost money is cash that he gets from staff as gifts or for payment for burning music CDs or downloading movies for staff onto portable drives, that is not recorded on his financials. [DSP #5] states [client S] did not tell him what staff had given him ghost money. [DSP #5] states that [client S] told him he had the code to the back security gate off the gym. [Client S] did not tell him how he got the code. [DSP #5] reports that [client S] had never said anything to him regarding a girlfriend but that when he reported to his direct supervisor, [RM #3], RM on Thursday (sic) regarding the texting, the gate code and the ghost money, that [RM #3] told him he (RM #3) suspected that [RM #1], RM was [client S's] girlfriend.... "</p> <p>The facility's 8/30/15 investigation indicated DSP #6 was interviewed in regard to the allegation of abuse. DSP #6's witness statement indicated client S</p>						

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	<p>had told DSP #6 about the "ghost money." DSP #6's summary indicated "...She (DSP #6) describes it as money he gets from staff for burning music CD's...She (DSP #6) further states that [client S] has told her that [RM #5], RM and [DSP #2], DSP have promised to give him an automobile when he is released from ResCare. [DSP #6] states that she (sic) [client S] has what she referred to as a crush on [RM #1]...."</p> <p>The facility's 8/30/15 summary indicated DSP #7 was interviewed. DSP #7's summary indicated client S had told the staff person about his "ghost money" from where client S made music CDs for staff. DSP #7's witness statement indicated DSP #7 had bought the client a pop on one occasion when they were at the county fair. DSP #7's summary indicated she did not purchase any CDs from client S. DSP #7's summary also indicated client S was with RM #1 "a lot." The summary indicated "...[DSP #7] states that she had witnessed [RM #1] dancing for [client S]. She (DSP #7) reports that she walked into [client S's] room and that he was video recording [RM #1] dancing on his tablet. She states that when [RM #1] saw her, she was very surprised and told [client S] that he must erase the video.... "</p>						

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	<p>-8/30/15 investigation indicated "During the course of an abuse investigation, allegations regarding policy violations were made, including but not limited to; staff providing muscle relaxers to consumers, staff making purchases of pirated music and movies from consumers, staff bringing in candy, sugary soft drinks and energy drinks for consumers, staff and consumers texting one another on personal cell phones, consumers selling electronics to staff, staff furnishing consumers with electronic devices and staff failing to report policy violations."</p> <p>Interview with administrative staff #1, the Program Manager (PM), the Qualified Intellectual Disabilities Professional (QIDP) and Quality Assurance (QA) staff #1 on 9/16/15 at 1:09 PM and at 1:55 PM indicated client S no longer lived at the facility. Administrative staff #1 and the QIDP indicated client S signed himself out and left the facility. The PM, administrative staff #1 and QA staff #1 indicated client S was texting facility staff from a computer tablet which was given to the client. Administrative staff indicated the client was taking orders for burning CDs and downloading movies from staff which the facility staff were paying the client. Administrative staff #1 indicated</p>						

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	<p>the money client S made was not being documented on the client's financial log. Administrative staff #1 and the QA staff indicated they did not know how client S received the codes to the gate. The QIDP, PM, administrative staff #1 and the QA staff stated client S's functioning level was "very high." Administrative staff #1 stated client S was able to "manipulate staff to get what he wanted." When asked why did client S leave the facility, administrative staff #1 stated "he was running this racket in [name of previous facility]. The trafficking ring was busted up. He was upset his trafficking was stopped and his 1:1 staffing was stopped." Administrative staff #1 indicated when client S was 1:1 with staff, "He had a free pass to do what he wanted." Administrative staff #1 and QA staff #1 stated client S was "exploited by staff" as DSP #2 brought the client a computer tablet to download movies and burn CDs for staff. QA staff #1, PM and administrative staff #1 indicated facility staff had been retrained on "Professional Boundaries." QA staff #1 and administrative staff #1 indicated facility staff were buying the client pop, candy and computer items. QA staff #1 indicated client S admitted he was getting things from staff but would not identify who had given him things and/or who was purchasing CDs/downloaded movies</p>						

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	<p>from him.</p> <p>The facility's policy and procedures were reviewed on 9/16/15 at 12:05 PM. The facility's 3/1/11 policy entitled "Professional Boundaries indicated " ResCare expects employees to follow certain rules of conduct that will protect the interest and safety of the people we serve, our employees and the organization. In order to provide a safe, effective, professional environment, employees are required to maintain professional relationships with clients and their families...All employees are responsible for conducting themselves in a professional manner that provides respect to others. Employees shall treat clients in a humane manner at all times and shall not engage in behavior that is abusive,.... " The 3/1/11 policy indicated " ...F. The following activities are expressly prohibited:...3. Revealing personal information, including, but not limited to home address, phone number, religious beliefs or values, or family information, outside of a planned and therapeutic context. 4. Contact with clients outside of work responsibilities without prior authorization. 5. Giving gifts, favors or services to one client or a group of clients to the exclusion of others, beyond those required or authorized by the company. 6.</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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	<p>Acceptance of gifts of monetary value, favors, or services from the clients or clients' family members. 7. Any form of sexual contact with clients or a client's family member...8. Conducting any sort of business relationship with the client or the client's family.... "</p> <p>This federal tag relates to complaint #IN00181507.</p> <p>5-1.2(5)(d)</p>						