STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G194	A. BUILDING 00 B. WING	06/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	115 STONEGATE BEDFORD, IN 47421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for an investigation of complaint #IN00174360. Complaint #IN00174360: Substantiated, Federal and State deficiencies related to the allegation(s) cited at W104, W153 and W9999. Dates of Survey: June 8 and 9, 2015 Facility number: 000724 Provider number: 15G194 AIM number: 100243320 These deficiencies also reflect state findings in accordance with 460 IAC 9.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 6 of 7 clients living at the group home (A, B, C, E, F and G - client D was on a home visit at the time of the incident), the facility's governing body failed to	W 0104	**PROVIDER IDENTIFICATION #: 15G194** **NAME OF PROVIDER: RESCARE COMMUNITY ALT.,**	07/09/2015

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

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	exercise operating direction over the facility by failing to ensure the group home's septic system was maintained and inspected on a regular basis. Findings include: A review of the facility's incident reports was conducted on 6/9/15 at 10:29 AM. There were no incident reports to review regarding the issue on 5/25/15 and 5/26/15. On 6/9/15 at 10:36 AM, a receipt from the septic system service company indicated the septic system was pumped on 5/26/15. This affected clients A, B, C, E, F and G. On 6/8/15 at 2:50 PM, direct care staff #2 indicated on 5/25/15, the septic system backed up. Staff #2 indicated the septic system was repaired within 24 hours on 5/26/15. Staff #2 indicated she contacted maintenance to report the septic system was backed up into the shower. Staff #2 indicated there was one working toilet at the time. Staff #2 indicated the staff eventually put up a curtain outside to have the clients urinate outside when both toilets stopped working. Staff #2 indicated she contacted the Residential Manager (RM) to report the issue. Staff #2 indicated the RM contacted the group		**SOUTH CENTRAL** **ADDESS: 115 Stonegate, Bedford, IN 47421** **SURVEY EVENT ID #:** Q 9Y411 **DATE SURVEY COMPLETED:** 06/09/2015 **PROVIDER'S PLAN OF CORRECTION** **W104:Governing Body** § The governing body must exercise general policy, budget, and operating direction over facility. **Corrective action:** · Septic system has been flushed by Kings Septic on 5/26/2015, · Septic system inspected by David Gaither Excavating on 6/25/2015 · Inspector identified mechanical issue with pump and	

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	home's main office to report the issue. Staff #2 indicated the clients were not evacuated. Staff #2 indicated she worked on 5/26/15 during the morning shift. Staff #2 stated when she arrived, the group home smelled "bad." Staff #2 indicated she used a bleach water solution to clean the shower and toilets after the septic system was repaired. Staff #2 indicated she was told the issue was caused by wipes being flushed down the toilet. Staff #2 indicated there were no client behaviors related to the septic issues at the group home. On 6/8/15 at 3:58 PM, staff #2 indicated one of the toilets worked until the middle of the night. Staff #2 stated, "it got nasty." Staff #2 indicated the septic system had never been flushed for the 5 years the home had been open. On 6/8/15 at 3:16 PM, staff #6 indicated she worked during the evening shift (3:30 PM to 11:00 PM) on 5/25/15 until 11:00 PM. Staff #6 indicated one toilet worked for most of the shift. Staff #6 indicated none of the clients had to urinate outside during her shift on 5/25/15. Staff #6 indicated there were no client behaviors related to the septic issues at the group home. On 6/8/15 at 3:21 PM, the RM indicated a septic repair company came to the		ordered replacement part on 6/25/2015 · David Gaither Excavating is scheduled to replace pump on 6/29/2015 **How we will identify others:** · Annual inspection to prevent subsequent failures will be conducted by Kings Septic Service. **Measures to be put in place:** · Routine preventative maintenance to be done annually by local service provider. **Monitoring of Corrective Action:** · Program Manager and Maintenance personnel scheduled inspection, approved repairs, and scheduled repairs. · Maintenance personnel will monitor repair progress, and report completion to Program Manager. · Program Manager and Maintenance personnel scheduled routine preventative	

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	home on 5/26/15 to repair the septic system. The RM indicated when the issue was reported to her, she reported it to the Group Home Operations Manager (GHOM). The RM indicated the GHOM called the maintenance staff. The RM indicated the maintenance staff attempted to find someone to come to the home on 5/25/15 to repair the system however the earliest someone could come was on 5/26/15. The RM indicated the septic system had not been cleaned out in 5 years since the home opened. The RM indicated she went to the home on 5/25/15 to assess the situation. The RM stated it "didn't smell that bad." The RM indicated she requested to have the clients moved to a hotel from the GHOM but did not hear back about her request. The RM indicated the clients would have been evacuated on 5/26/15 if the issue was not resolved. On 6/8/15 at 3:47 PM, the RM indicated there was no maintenance request completed. The RM indicated she sent her request by text however the text has since been deleted from her phone. On 6/8/15 at 3:58 PM, the RM indicated she was not aware the clients were asked to urinate outside the group home. On 6/8/15 at 4:42 PM, the maintenance staff (MS) indicated the group home had been open for 5 years and the septic		maintenance. · Maintenance personnel will confirm routine maintenance and report completion to Program Manager. **Completion Date: 7-09-2015**	

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	system had never been flushed or serviced to empty it. The MS indicated the system backed up due to wipes being flushed down the toilet. The MS indicated the system got clogged up and the waste would not leach out of the finger system. The MS indicated the septic system did not need to be pumped out on a schedule. The MS indicated once time a year he added enzymes to the system. The MS indicated when he was at the home on 5/26/15 the toilets were full of feces and the walk in shower had sewage in it from the drain backing up. The MS indicated the bathroom doors were closed and the exhaust fans were on. The MS indicated the septic system included two tanks. On 6/8/15 at 5:37 PM, staff #1 indicated on 5/25/15 around 2:30 PM, the septic system backed up. Staff #1 indicated she contacted the RM who called the MS. Staff #1 indicated the direct care staff did everything they could to get the situation resolved. Staff #1 indicated she worked the next day and was told to have the clients outside but she did not recall who told her this information. Staff #1 indicated the septic system was repaired on 5/26/15. Staff #1 indicated the clients should have been evacuated to a hotel. On 6/8/15 at 7:51 PM, staff #4 indicated			

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	he worked the overnight shift on 5/25/15 to 5/26/15. Staff #4 stated, "it was disgusting. I have no idea why they kept them in the home. It was disgusting." Staff #4 indicated the clients were using the toilets but the toilets could not be flushed. Staff #4 indicated the clients should have been evacuated to a hotel. Staff #4 indicated there was feces in the walk in shower. Staff #4 indicated the overnight staff tried to clean up the mess the best they could. Staff #4 indicated the smell was bad in the bathrooms but the staff kept the doors closed with the fans on. On 6/8/15 at 8:00 PM, staff #3 indicated she worked the overnight shift on 5/25/15 to 5/26/15. Staff #3 indicated the big shower had feces in it. Staff #3 indicated she was told to not use the toilets. Staff #3 indicated the clients had to urinate outside. Staff #3 indicated the clients should have been taken to a hotel. Staff #3 indicated the septic system was repaired the next day. On 6/9/15 at 9:52 AM, the GHOM indicated on 5/25/15, she received a phone call reporting issues with the group home's septic system. The GHOM stated it was reported the shower drain and the drain in the garage were backed up and smelled "sulfury." The GHOM indicated			

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	she contacted the MS who attempted to find someone to address the issue on 5/25/15. The GHOM indicated she discussed evacuating the clients with her supervisor however the clients were not evacuated. The GHOM indicated she was never informed there was feces in the shower. The GHOM indicated she was told the toilets and the tub were still working. The GHOM indicated the RM went to the home to assess the situation. The RM reported the sinks and toilets were operational. The GHOM indicated it was never reported to her the toilets stopped working. The GHOM indicated it was not reported to her there was feces in the shower. The GHOM indicated she was not aware and did not instruct staff to take the clients outside to urinate. The GHOM indicated she was not aware of a schedule to empty or service the septic system. The GHOM indicated the group home had running water, sinks and toilets. The GHOM indicated she was not aware the toilets stopped working and were not able to be used. The GHOM indicated she was told the toilets were working. The GHOM indicated she did not go to the group home to assess the situation. On 6/9/15 at 11:01 AM, the Executive Director (ED) indicated she was not aware of a septic system issue at the			

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	group home until 6/8/15. The ED indicated she had not been contacted and was not aware of an issue with the septic system. The ED indicated the GHOM reported to her on 6/8/15 that she was contacted by the RM on 5/25/15 of an odor at the group home. The ED indicated the GHOM reported everything was working but there was an odor in the home. The ED indicated the septic system company was called and was there by noon on 5/26/15. The ED indicated the GHOM reported that the staff said the toilets stopped working around 2:00 to 3:00 AM. The ED indicated one or more clients urinated outside the group home due to the toilets not working. The ED stated, "I have no idea why I was not notified." The ED indicated she did not discuss evacuating the clients due to not having knowledge of the situation until 6/8/15. The ED indicated the maintenance staff should have gone to the home to assess the situation and she should have been notified. The ED indicated if there was a tank in the septic system, it needed to be emptied regularly and routinely inspected and serviced. The ED indicated since the toilets stopped working, the clients should have been evacuated from the home. This federal tag relates to complaint			

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	#IN00174360. 9-3-1(a)			
W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 6 of 7 clients living at the group home (A, B, C, E, F and G - client D was on a home visit at the time of the incident), the facility failed to ensure staff immediately reported the toilets stopped working at the group home to the administrator. Findings include: A review of the facility's incident reports was conducted on 6/9/15 at 10:29 AM. There were no incident reports to review regarding the issue on 5/25/15 and 5/26/15.	W 0153	**PROVIDER IDENTIFICATION #: 15G194 NAME OF PROVIDER: RESCARE COMMUNITY ALT., SOUTH CENTRAL ADDESS: 115 Stonegate, Bedford, IN 47421 SURVEY EVENT ID #:** Q 9Y411 **DATE SURVEY COMPLETED:** 06/09/2015 **PROVIDER'S PLAN OF CORRECTION** **W 153 483.420(d)(2) STAFF TREATMENT OF CLIENTS** § The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the	07/09/2015

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	On 6/9/15 at 10:36 AM, a receipt from the septic system service company indicated the septic system was pumped on 5/26/15. This affected clients A, B, C, E, F and G. On 6/8/15 at 2:50 PM, direct care staff #2 indicated on 5/25/15, the septic system backed up. Staff #2 indicated the septic system was repaired within 24 hours on 5/26/15. Staff #2 indicated she contacted maintenance to report the septic was backed up into the shower. Staff #2 indicated there was one working toilet at the time. Staff #2 indicated the staff eventually put up a curtain outside to have the clients urinate outside when both toilets stopped working. Staff #2 indicated she contacted the Residential Manager (RM) to report the issue. Staff #2 indicated the RM contacted the group home's main office to report the issue. Staff #2 indicated the clients were not evacuated. Staff #2 indicated she worked on 5/26/15 during the morning shift. Staff #2 stated when she arrived, the group home smelled "bad." Staff #2 indicated she used a bleach water solution to clean the shower and toilets after the septic system was repaired. Staff #2 indicated she was told the issue was caused by wipes being flushed down the toilet. Staff #2 indicated there were		administrator or to other officials in accordance with State law through established procedures. **Corrective action:** · All employees working the evening of the septic issue have received progressive discipline concerning failure to identify severity of conditions to administrative personnel. (ATTACHMENT A) · A BDDS report was submitted to notify the state of this incident within 24 hours of knowledge to Clinical Supervisor and Administrator. (ATTACHMENT B) **How we will identify others:** · Annual inspection to prevent subsequent failures will be conducted by Kings Septic Service. · All employees will receive monthly training on reporting policy and procedures. **Measures to be put in place:**	

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	no client behaviors related to the septic issues at the group home. On 6/8/15 at 3:58 PM, staff #2 indicated one of the toilets worked until the middle of the night. Staff #2 stated, "it got nasty." Staff #2 indicated the septic system had never been flushed for the 5 years the home had been open. On 6/8/15 at 3:16 PM, staff #6 indicated she worked during the evening shift (3:30 PM to 11:00 PM) on 5/25/15 until 11:00 PM. Staff #6 indicated one toilet worked for most of the shift. Staff #6 indicated none of the clients had to urinate outside during her shift on 5/25/15. Staff #6 indicated there were no client behaviors related to the septic issues at the group home. On 6/8/15 at 3:21 PM, the RM indicated a septic repair company came to the home on 5/26/15 to repair the septic system. The RM indicated when the issue was reported to her, she reported it to the Group Home Operations Manager (GHOM). The RM indicated the GHOM called the maintenance staff. The RM indicated the maintenance staff attempted to find someone to come to the home on 5/25/15 to repair the system however the earliest someone could come was on 5/26/15. The RM indicated the septic system had not been cleaned out in 5		· Routine preventative maintenance to be done annually by local service provider. · Residential Manager will conduct monthly training meetings to reinforce the employee knowledge of reporting policies and procedures. (ATTACHMENT C) · Residential Manager will conduct monthly training meetings to reinforce the employee knowledge of Abuse, Neglect, and mistreatment definition, policies, and procedures. (ATTACHMENT C) **Monitoring of Corrective Action:** · Program Manager and Maintenance personnel scheduled inspection, approved repairs, and scheduled repairs. · Maintenance personnel will monitor repair progress, and report completion to Program Manager. · Program Manager and Maintenance personnel scheduled routine preventative maintenance. · Maintenance personnel will	

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	years since the home opened. The RM indicated she went to the home on 5/25/15 to assess the situation. The RM stated it "didn't smell that bad." The RM indicated she requested to have the clients moved to a hotel from the GHOM but did not hear back about her request. The RM indicated the clients would have been evacuated on 5/26/15 if the issue was not resolved. The RM indicated the incident was not reported to the Bureau of Developmental Disabilities Services (BDDS). On 6/8/15 at 3:47 PM, the RM indicated there was no maintenance request completed. The RM indicated she sent her request by text however the text has since been deleted from her phone. On 6/8/15 at 3:58 PM, the RM indicated she was not aware the clients were asked to urinate outside the group home. On 6/8/15 at 4:42 PM, the maintenance staff (MS) indicated the group home had been open for 5 years and the septic system had never been flushed or serviced to empty it. The MS indicated the system backed up due to wipes being flushed down the toilet. The MS indicated the system got clogged up and the waste would not leach out of the finger system. The MS indicated the septic system did not need to be pumped out on a schedule. The MS indicated		confirm routine maintenance and report completion to Program Manager. · Clinical Supervisor will review monthly meeting agendas to ensure trainings are completed. **Completion Date: 7-09-2015**	

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	once time a year he added enzymes to the system. The MS indicated when he was at the home on 5/26/15 the toilets were full of feces and the walk in shower had sewage in it from the drain backing up. The MS indicated the bathroom doors were closed and the exhaust fans were on. The MS indicated the septic system included two tanks. On 6/8/15 at 5:37 PM, staff #1 indicated on 5/25/15 around 2:30 PM, the septic system backed up. Staff #1 indicated she contacted the RM who called the MS. Staff #1 indicated the direct care staff did everything they could to get the situation resolved. Staff #1 indicated she worked the next day and was told to have the clients outside but she did not recall who told her this information. Staff #1 indicated the septic system was repaired on 5/26/15. Staff #1 indicated the clients should have been evacuated to a hotel. On 6/8/15 at 7:51 PM, staff #4 indicated he worked the overnight shift on 5/25/15 to 5/26/15. Staff #4 stated, "it was disgusting. I have no idea why they kept them in the home. It was disgusting." Staff #4 indicated the clients were using the toilets but the toilets could not be flushed. Staff #4 indicated the clients should have been evacuated to a hotel. Staff #4 indicated there was feces in the			

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	walk in shower. Staff #4 indicated the overnight staff tried to clean up the mess the best they could. Staff #4 indicated the smell was bad in the bathrooms but the staff kept the doors closed with the fans on. On 6/8/15 at 8:00 PM, staff #3 indicated she worked the overnight shift on 5/25/15 to 5/26/15. Staff #3 indicated the big shower had feces in it. Staff #3 indicated she was told to not use the toilets. Staff #3 indicated the clients had to urinate outside. Staff #3 indicated the clients should have been taken to a hotel. Staff #3 indicated the septic system was repaired the next day. On 6/9/15 at 9:52 AM, the GHOM indicated on 5/25/15, she received a phone call reporting issues with the group home's septic system. The GHOM stated it was reported the shower drain and the drain in the garage were backed up and smelled "sulfury." The GHOM indicated she contacted the MS who attempted to find someone to address the issue on 5/25/15. The GHOM indicated she discussed evacuating the clients however the clients were not evacuated. The GHOM indicated she was never informed there was feces in the shower. The GHOM indicated she was told the toilets and the tub were still working. The			

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	15G194	A. BUILDING 00 B. WING	06/09/2015

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	GHOM indicated the RM went to the home to assess the situation. The RM reported the sinks and toilets were operational. The GHOM indicated it was never reported to her the toilets stopped working. The GHOM indicated it was not reported to her there was feces in the shower. The GHOM indicated she was not aware and did not instruct staff to take the clients outside to urinate. The GHOM indicated she was not aware of a schedule to empty or service the septic system. The GHOM indicated the situation was not reported to BDDS since the clients did not evacuate. The GHOM indicated the group home had running water, sinks and toilets. The GHOM indicated she was not aware the toilets stopped working and were not able to be used. The GHOM indicated she was told the toilets were working. The GHOM indicated she did not go to the group home to assess the situation. On 6/9/15 at 11:01 AM, the Executive Director (ED) indicated she was not aware of a septic system issue at the group home until 6/8/15. The ED indicated she had not been contacted and was not aware of an issue with the septic system. The ED indicated the GHOM reported to her on 6/8/15 that she was contacted by the RM on 5/25/15 of an odor at the group home. The ED			

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	indicated the GHOM reported everything was working but there was an odor in the home. The ED indicated the septic system company was called and was there by noon on 5/26/15. The ED indicated the GHOM reported that the staff said the toilets stopped working around 2:00 to 3:00 AM. The ED indicated one or more clients urinated outside the group home due to the toilets not working. The ED stated, "I have no idea why I was not notified." The ED indicated she did not discuss evacuating the clients due to not having knowledge of the situation until 6/8/15. The ED indicated the maintenance staff should have gone to the home to assess the situation and she should have been notified. The ED indicated if there was a tank in the septic system, it needed to be emptied regularly and routinely inspected and serviced. The ED indicated BDDS should have been notified since the toilets stopped working. The ED indicated since the toilets stopped working, the clients should have been evacuated from the home. This federal tag relates to complaint #IN00174360. 9-3-2(a)			

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W 9999 Bldg. 00	State Findings The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met: 460 IAC 9-3-1 Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division: 6. A service delivery site that jeopardizes or compromises the health or welfare of an individual. This state rule was not met as evidenced by: Based on record review and interview for 6 of 7 clients living at the group home (A, B, C, E, F and G), the facility failed to report to the Bureau of Developmental Disabilities Services (BDDS) the group home's septic system failed to function on 5/25/15 and 5/26/15.	W 9999	**PROVIDER IDENTIFICATION #: 15G194 NAME OF PROVIDER: RESCARE COMMUNITY ALT., SOUTH CENTRAL ADDESS: 115 Stonegate, Bedford, IN 47421 SURVEY EVENT ID #:** Q 9Y411 **DATE SURVEY COMPLETED:** 06/09/2015 **PROVIDER'S PLAN OF CORRECTION** **W9999 Final Observations** § The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division: 6. A service delivery site that jeopardizes or compromises the health or welfare of an individual **Corrective action:** · Septic system has been flushed by Kings Septic on 5/26/2015, · Septic system inspected by	07/09/2015

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	Findings include: On 6/9/15 at 10:29 AM, a review of the facility's incident reports was conducted. There was no documentation the facility reported the group home's septic system failed to function on 5/25/15 and 5/26/15 affecting clients A, B, C, E, F and G. A review of the facility's incident reports was conducted on 6/9/15 at 10:29 AM. There were no incident reports to review regarding the issue on 5/25/15 and 5/26/15. On 6/9/15 at 10:36 AM, a receipt from the septic system service company indicated the septic system was pumped on 5/26/15. On 6/8/15 at 2:50 PM, direct care staff #2 indicated on 5/25/15, the septic system backed up. Staff #2 indicated the septic system was repaired within 24 hours on 5/26/15. Staff #2 indicated she contacted maintenance to report the septic was backed up into the shower. Staff #2 indicated there was one working toilet at the time. Staff #2 indicated the staff eventually put up a curtain outside to have the clients urinate outside when both toilets stopped working. Staff #2 indicated she contacted the Residential		David Gaither Excavating on 6/25/2015 · Inspector identified mechanical issue with pump and ordered replacement part on 6/25/2015 · David Gaither Excavating is scheduled to replace pump on 6/29/2015 · All employees working the evening of the septic issue have received progressive discipline concerning failure to identify severity of conditions to administrative personnel. (ATTACHMENT A) · A BDDS report was submitted to notify the state of this incident within 24 hours of knowledge to Clinical Supervisor and Administrator. (ATTACHMENT B) **How we will identify others:** · Annual inspection to prevent subsequent failures will be conducted by Kings Septic Service. · All employees will receive monthly training on reporting policy and procedures.	

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	Manager (RM) to report the issue. Staff #2 indicated the RM contacted the group home's main office to report the issue. Staff #2 indicated the clients were not evacuated. Staff #2 indicated she worked on 5/26/15 during the morning shift. Staff #2 stated when she arrived, the group home smelled "bad." Staff #2 indicated she used a bleach water solution to clean the shower and toilets after the septic system was repaired. Staff #2 indicated she was told the issue was caused by wipes being flushed down the toilet. Staff #2 indicated there were no client behaviors related to the septic issues at the group home. On 6/8/15 at 3:58 PM, staff #2 indicated one of the toilets worked until the middle of the night. Staff #2 stated, "it got nasty." Staff #2 indicated the septic system had never been flushed for the 5 years the home had been open. On 6/8/15 at 3:16 PM, staff #6 indicated she worked during the evening shift (3:30 PM to 11:00 PM) on 5/25/15 until 11:00 PM. Staff #6 indicated one toilet worked for most of the shift. Staff #6 indicated none of the clients had to urinate outside during her shift on 5/25/15. Staff #6 indicated there were no client behaviors related to the septic issues at the group home.		**Measures to be put in place:** · Routine preventative maintenance to be done annually by local service provider. · Residential Manager will conduct monthly training meetings to reinforce the employee knowledge of reporting policies and procedures. (ATTACHMENT C) · Residential Manager will conduct monthly training meetings to reinforce the employee knowledge of Abuse, Neglect, and mistreatment definition, policies, and procedures. (ATTACHMENT C) **Monitoring of Corrective Action:** · Program Manager and Maintenance personnel scheduled inspection, approved repairs, and scheduled repairs. · Maintenance personnel will monitor repair progress, and report completion to Program Manager. · Program Manager and Maintenance personnel scheduled routine preventative maintenance. · Maintenance personnel will	

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	On 6/8/15 at 3:21 PM, the RM indicated a septic repair company came to the home on 5/26/15 to repair the septic system. The RM indicated when the issue was reported to her, she reported it to the Group Home Operations Manager (GHOM). The RM indicated the GHOM called the maintenance staff. The RM indicated the maintenance staff attempted to find someone to come to the home on 5/25/15 to repair the system however the earliest someone could come was on 5/26/15. The RM indicated the septic system had not been cleaned out in 5 years since the home opened. The RM indicated she went to the home on 5/25/15 to assess the situation. The RM stated it "didn't smell that bad." The RM indicated she requested to have the clients moved to a hotel from the GHOM but did not hear back about her request. The RM indicated the clients would have been evacuated on 5/26/15 if the issue was not resolved. On 6/8/15 at 3:47 PM, the RM indicated there was no maintenance request completed. The RM indicated she sent her request by text however the text has since been deleted from her phone. On 6/8/15 at 3:58 PM, the RM indicated she was not aware the clients were asked to urinate outside the group home. On 6/8/15 at 4:42 PM, the maintenance		confirm routine maintenance and report completion to Program Manager. · Clinical Supervisor will review monthly meeting agendas to ensure trainings are completed. **Completion Date: 7-09-2015**	

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	staff (MS) indicated the group home had been open for 5 years and the septic system had never been flushed or serviced to empty it. The MS indicated the system backed up due to wipes being flushed down the toilet. The MS indicated the system got clogged up and the waste would not leach out of the finger system. The MS indicated the septic system did not need to be pumped out on a schedule. The MS indicated once time a year he added enzymes to the system. The MS indicated when he was at the home on 5/26/15 the toilets were full of feces and the walk in shower had sewage in it from the drain backing up. The MS indicated the bathroom doors were closed and the exhaust fans were on. The MS indicated the septic system included two tanks. On 6/8/15 at 5:37 PM, staff #1 indicated on 5/25/15 around 2:30 PM, the septic system backed up. Staff #1 indicated she contacted the RM who called the MS. Staff #1 indicated the direct care staff did everything they could to get the situation resolved. Staff #1 indicated she worked the next day and was told to have the clients outside but she did not recall who told her this information. Staff #1 indicated the septic system was repaired on 5/26/15. Staff #1 indicated the clients should have been evacuated to a hotel.			

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On 6/8/15 at 7:51 PM, staff #4 indicated he worked the overnight shift on 5/25/15 to 5/26/15. Staff #4 stated, "it was disgusting. I have no idea why they kept them in the home. It was disgusting." Staff #4 indicated the clients were using the toilets but the toilets could not be flushed. Staff #4 indicated the clients should have been evacuated to a hotel. Staff #4 indicated there was feces in the walk in shower. Staff #4 indicated the overnight staff tried to clean up the mess the best they could. Staff #4 indicated the smell was bad in the bathrooms but the staff kept the doors closed with the fans on.

On 6/8/15 at 8:00 PM, staff #3 indicated she worked the overnight shift on 5/25/15 to 5/26/15. Staff #3 indicated the big shower had feces in it. Staff #3 indicated she was told to not use the toilets. Staff #3 indicated the clients had to urinate outside. Staff #3 indicated the clients should have been taken to a hotel. Staff #3 indicated the septic system was repaired the next day.

On 6/9/15 at 9:52 AM, the GHOM indicated on 5/25/15, she received a phone call reporting issues with the group home's septic system. The GHOM stated it was reported the shower drain and the

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	drain in the garage were backed up and smelled "sulfury." The GHOM indicated she contacted the MS who attempted to find someone to address the issue on 5/25/15. The GHOM indicated she discussed evacuating the clients with her supervisor however the clients were not evacuated. The GHOM indicated she was never informed there was feces in the shower. The GHOM indicated she was told the toilets and the tub were still working. The GHOM indicated the RM went to the home to assess the situation. The RM reported the sinks and toilets were operational. The GHOM indicated it was never reported to her the toilets stopped working. The GHOM indicated it was not reported to her there was feces in the shower. The GHOM indicated she was not aware and did not instruct staff to take the clients outside to urinate. The GHOM indicated the group home had running water, sinks and toilets. The GHOM indicated she was not aware the toilets stopped working and were not able to be used. The GHOM indicated she was told the toilets were working. The GHOM indicated she did not go to the group home to assess the situation. The GHOM indicated the incident at the group home was not reported to BDDS due to the clients not being evacuated from the group home.			

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	On 6/9/15 at 11:01 AM, the Executive Director (ED) indicated she was not aware of a septic system issue at the group home until 6/8/15. The ED indicated she had not been contacted and was not aware of an issue with the septic system. The ED indicated the GHOM reported to her on 6/8/15 that she was contacted by the RM on 5/25/15 of an odor at the group home. The ED indicated the GHOM reported everything was working but there was an odor in the home. The ED indicated the septic system company was called and was there by noon on 5/26/15. The ED indicated the GHOM reported that the staff said the toilets stopped working around 2:00 to 3:00 AM. The ED indicated one or more clients urinated outside the group home due to the toilets not working. The ED indicated the maintenance staff should have gone to the home to assess the situation and she should have been notified. The ED indicated if there was a tank in the septic system, it needed to be emptied regularly and routinely inspected and serviced. The ED indicated since the toilets stopped working, the clients should have been evacuated from the home. The ED indicated the incident should have been reported to BDDS. This federal tag relates to complaint			

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