STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 00 B. WING	02/18/2019

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RES CARE COMMUNITY ALTERNATIVES SE IN	13009 HORIZON DR MEMPHIS, IN 47143

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W 0000 Bldg. 00	This visit was for the investigation of Complaint #IN00284619. Complaint #IN00284619: Substantiated, Federal/State deficiencies related to the allegation are cited at W122, W149 and W157. Survey dates: February 14, 15 and 18, 2019. Facility Number: 004615 Provider Number: 15G723 AIM Number: 200528230 These federal deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/6/19.	W 0000		
W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, record review and interview for 1 of 2 sampled clients (A), the Condition of Participation: Client Protections was not met. The facility neglected to implement policies and procedures to ensure the rights of all clients to be free of neglect by neglecting to protect client A from the influence of a relative who encouraged him to refuse his prescribed medications and who failed to comply with agreed upon rules and failed to provide receipts for client A's purchases with his own money during a visit. Findings include: 1. The facility failed to ensure the facility's	W 0122	1. The Program Manager will ensure the Area Supervisor and Residential Manager retrain direct care staff on the Abuse, Neglect and Exploitation Policy. Failure to follow policy will result in disciplinary action up to and including termination. 2. Upon return of Client A to the facility, a no trespassing/contact order between Client A and Relative to prevent contact was initiated and is being enforced by Clark County Sheriff's Department.	03/20/2019

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

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	neglect/abuse/mistreatment policy was implemented regarding staff neglect to keep client A from a repeat visit with his relative after a visit in which she did not ensure he took prescribed medications and returned to the facility as promised. Please see W149. 2. The facility neglected to implement corrective measures to keep client A from a repeat visit with his relative wherein she failed to return receipts for items purchased with client A's money and encouraged him to not take his prescribed medications. Please see W157. This federal tag relates to Complaint #IN00284619. 9-3-2(a)		The facility administrator petitioned for an Emergency Protective Order that was served to Relative and the order was granted on 3/14/2019. The facility administrator will contact the Clark County Sheriff's Department in the event of attempted contact by Relative with Client A. 3. ResCare received a request for $130 of personal spending money for which no receipts were received. Client A has been reimbursed $130 for the unaccounted funds. The Program Manager Area Supervisor and Residential manager will be re-trained on policy for request of personal funds. Failure to follow the policy will result in disciplinary action up to and including termination. 4. Before any client leaves the Facility, the guardian/family/friends the client will be departing with will be trained on the medical administration standard and will sign a Leave of Absence Form before the client is released to leave. Upon return, the Facility will ensure medication was administered appropriately, if not the client will be assessed by the Nurse, and the incident will be reported to Quality Assurance for submission of an incident report.	

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			Monitoring of Corrective Action: The Program Manager, Area Supervisor, and Residential Manager will ensure all allegations of abuse, neglect and exploitation are reported to the Quality Assurance department. The Program Manager, Quality Assurance, QIDP, Nursing, Behavior Clinician, Area Supervisor and Residential Manager from the facility will meet weekly for 90 days to review all reports and ensure accurate reporting of abuse, neglect or exploitation. The Residential Manager will review daily documentation to ensure accurate reporting has been completed for 90 days. Administrative staff will complete a minimum of three unannounced visits weekly for 90 days for monitoring. The Residential Manager will ensure all incidents are reported to QA and QA will review all incident reports and follow the abuse, neglect and exploitation policy when applicable. **Persons Responsible: Program Manager, Nurse, QA, Business Manager, Area Supervisor, QIDP, Residential Manager, and DSPs.**	
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement			

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	written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 2 sampled clients (A), for 3 of 5 investigations of abuse/neglect/exploitation reviewed, the facility failed to ensure the facility's neglect/abuse/mistreatment policy was implemented regarding staff neglect of client A. The facility failed to keep client A from a repeat visit with his relative after a visit in which she did not ensure he took prescribed medications and returned to the facility as promised. Findings include: The facility's Bureau of Developmental Disabilities Services/BDDS reports, incident reports and investigations were reviewed on 2/14/19 at 11:45 AM and on 2/18/19 at 10:00 AM and indicated the following: 1. A 1/16/19 BDDS report indicated an incident of 1/15/19 at 2:00 PM: "Narrative: [Client A] returned to the home after being on therapeutic leave with his [relative], [name] since December 15, 2018. When [name] took [Client A] home with her on 12/15/18 she stated he would not be returning to services. All medications and instructions for administration were provided to her at that time. On 1/15/2019, [Name] contacted [name], program manager and stated she could no longer care for [Client A] and was bringing him back to the group home. When [Client A] returned his [relative] stated she did not allow him to take any medications for over 20 days and no medications were returned to the home. The nurse completed an assessment of [Client A] and noted involuntary movement she believed to be tardive	W 0149	1. The Program Manager will ensure the Area Supervisor and Residential Manager retrain direct care staff on the Abuse, Neglect and Exploitation Policy. Failure to follow policy will result in disciplinary action up to and including termination. 2. Upon return of Client A to the facility, a no trespassing/contact order between Client A and Relative to prevent contact was initiated and is being enforced by Clark County Sheriff's Department. The facility administrator petitioned for an Emergency Protective Order that was served to Relative and the order was granted on 3/14/2019. The facility administrator will contact the Clark County Sheriff's Department in the event of attempted contact by Relative with Client A. 3. ResCare received a request for $130 of personal spending money for which no receipts were received. Client A has been reimbursed $130 for the unaccounted funds. The Program Manager Area Supervisor and Residential manager will be re-trained on policy for request of personal funds. Failure to follow the policy will result in disciplinary action up to and including termination.	03/20/2019

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	dyskinesia in nature. It was also noted by the nurse [Client A] had weight loss of 30-35lbs (pounds) since November 2018 and [Client A] was making nonsensical statements during the assessment. Due to all the concerns, the nurse instructed staff to take [Client A] to the ER (Emergency Room) for an evaluation. Plan to Resolve: [Client A] has been admitted to the behavioral unit at [name] hospital for further evaluation and ResCare remains in contact with the hospital for updates and discharge planning. The team is working with BDDS and APS (Adult Protective Services) to determine what protective measures can be implemented to ensure [Client A]'s safety upon his discharge from the hospital. In addition, the program manager spoke with APS via phone explaining the situation. APS is contacting [name] to inform her she is not to have any contact with [Client A] until she meets with APS." The 1/22/19 investigation regarding the 1/16/19 BDDS report indicated: "Factual Findings: [Client A], [name of relative], and [LPN #1] stated [client A] did not take his medications while away with his relative for more than 20 days. [Client A]'(s) [name of relative] did not want [client A] to take his medications until he was re-evaluated. [Client A] returned to the home (facility) with significant weight loss and obvious side effects from not taking his medications. Text messages from [name of relative] confirm [client A] was not taking his medications. Conclusion: It is substantiated [client A] did not take his		4. Before any client leaves the Facility, the guardian/family/friends the client will be departing with will be trained on the medical administration standard and will sign a Leave of Absence Form before the client is released to leave. Upon return, the Facility will ensure medication was administered appropriately, if not the client will be assessed by the Nurse, and the incident will be reported to Quality Assurance for submission of an incident report. 5. In the event an emancipated individual's decision puts them at risk of abuse, neglect or exploitation an IDT will be held to discuss and determine recommendations. The decision of the IDT will be presented to the Facility Executive Director for final approval. Monitoring of Corrective Action: The Program Manager, Area Supervisor, and Residential Manager will ensure all allegations of abuse, neglect and exploitation are reported to the Quality Assurance department. The Program Manager, Quality Assurance, QIDP, Nursing, Behavior Clinician, Area Supervisor and Residential Manager from the facility will meet weekly for 90 days to review all	

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	medications for 20 + (plus) days while with his [relative]. It is substantiated [client A]'(s) [relative] stopped his medications because she felt he was being overmedicated." The investigation's Peer Review dated 1/22/19 indicated the following recommendations: "1. Continue to follow agency protocols for therapeutic leaves. 2. APS and Ombudsman assisting with oversight of this case." A Follow-up BDDS Report dated 1/29/19 to the BDDS report of 1/16/19 for incident on 1/15/19 at 2:00 PM indicated: "[Client A] was discharged on 1/21/19 with a discharge diagnosis of Bipolar disorder and Klinefelter syndrome (genetic disorder). His lithium was discontinued. Zyprexa (olanzapine) was reduced from 40 mg QD (once daily) to 30 mg QD, and the Depakote (divalproex sodium) was increased from 500 mg BID (twice daily) to 750 mg BID. Instructions were also given for [client A] to follow up with his psychiatrist within 2 weeks. Staff have been trained on the changes and [client A] will follow up with his psychiatrist on 2/1/2019. In addition, [client A's] [relative] stated she did take him off his medications but did so because she believed he was over medicated. [Client A's] team, including his [relative], BDDS and APS met on 1/29/19 and came to the agreement [client A] will continue in services with ResCare and will take all medications as prescribed by his psychiatrist and PCP (primary care physician). If there are visits with [client A's] [relative], they will be closely monitored to ensure there are no recurring issues."		reports and ensure accurate reporting of abuse, neglect or exploitation. The Residential Manager will review daily documentation to ensure accurate reporting has been completed for 90 days. Administrative staff will complete a minimum of three unannounced visits weekly for 90 days for monitoring. The Residential Manager will ensure all incidents are reported to QA and QA will review all incident reports and follow the abuse, neglect and exploitation policy when applicable. **Persons Responsible: Executive Director, Program Manager, Nurse, QA, Business Manager, Area Supervisor, QIDP, Residential Manager, and DSPs.**	

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	Interview with Program Manager #1 on 2/14/19 at 11:18 AM indicated the hospital where client went after returning to the facility on 1/15/19 was informed to discharge client A only to the facility. Client A's relative had picked him up (1/20/19) without informing the facility from the behavioral unit at the local hospital. Program Manager/PM #1 went to the relative's house and brought client A back to the facility on 1/21/19. PM #1 indicated he had not allowed a home visit on 1/24/19. 2. A 2/12/19 BDDS report indicated an incident of 2/11/19 at 6:30 PM: Narrative: "On 2/3/2019 [client A] went on a home visit with his [relative] [name]. Upon returning to the group home on 2/11/19 it was determined [client A] did not take any of his medications while away from the group home. He has also refused to take any psychotropic medications since his return to the group home." Plan to Resolve: "[Client A] will be taken to the ER for an evaluation and a valproic acid level (Depakote/divalproex sodium) will be requested. In addition, visits with his [relative] are immediately suspended until the team, including BDDS, APS and the Ombudsman can meet to discuss what protective measures can be implemented to ensure [client A's] safety. In a previous team meeting on 1/29/19 with the aunt, BDDS, and APS it was agreed upon by all that [client A] would continue in services with ResCare and would take all medications as prescribed by his psychiatrist and PCR. That agreement was not honored during the home visit."			

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	Review (2/14/19 2:29 PM) of client A's financial records indicated he had requested personal funds on 2/5/19 to visit his brother out of state while visiting his relative. A check for $130.00 was drawn on client A's personal account dated 2/6/19 and the check was cashed by him on 2/7/19. Client A did not go out of state to visit his brother. He did not bring back any money or receipts when he returned on 2/11/19 from the visit. 3. A 2/13/19 BDDS report indicated an incident on 2/12/19 at 5:00 PM: Narrative: "[Client A] was speaking with the nurse prior to going to the ER...and alleged while with his [relative] he was exposed to people using drugs, stated the ResCare nurse and her family were in danger and the group home was at risk of being broken into. [Client A] stated he was fearful to be around his [relative] and the people she was associating with. An officer with the [local county] Sherriff's (sic) department was dispatched to the home and a report was filed...regarding the allegations." Plan to Resolve: "A restraining/no trespassing order was issued against [client A's] [relative] [name] and the access code to the group home has been changed. The team met with BDDS and APS on 2/13/19 and it was agreed there would be no visits allowed with the [relative]. In addition, a court appointed guardian was recommended by APS and the process immediately initiated. As [client A] is currently refusing his psych (psychiatric) medications and refusing to eat normally, he will follow up with his PCP 2/14/19 and a nutritional			

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	assessment will be requested. In addition, ResCare has contacted a psych hospital for inpatient medication evaluation and the hospital has agreed criteria is met and they will complete intake and evaluation as soon as a bed becomes available." During observations at the facility on 2/14/19 at 3:28 PM, client A was absent. Area Director/AD #1 indicated on 2/14/19 at 3:45 PM, QIDP/Qualified Intellectual Disability Professional #1 and staff #1 were with client A at the psychiatric hospital awaiting client A's admittance. AD #1 was asked to notify the surveyor if client A was not admitted and returned to the facility on 2/14/19. PM #1 called the surveyor (2/14/19 7:00 PM) and reported client A had not been accepted for inpatient treatment at the psychiatric hospital and was returning to the facility. During observations at the facility on 2/15/19 from 8:28 AM until 9:30 AM, client A was at his living facility. He was eating scrambled eggs and pears. Client A asked the surveyor if "they put something in them (did facility staff put something unknown in his eggs or pears)?" Client A's upper body leaned to the left and his torso would jerk periodically. The movements were involuntary. Client A indicated he was having difficulty eating but the fruit seemed to go down well. Client C obtained more pears from the refrigerator for client A. Residential Manager #1 offered client A a glass of milk after he stated his eggs might "come back up." Client A indicated he had visited a relative recently and he had not been taking his medications during the visits. Client A went to a local workshop and was observed there from 9:56 AM until 11:17 AM on 2/15/19. Client A was prompted by RM #1 to do a job of putting long			

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	plastic tubes into baggies. Client A did an assembly job next which he seemed to enjoy more. Review of client A's record on 2/15/19 at 2:57 PM indicated an ISP/Individual Support Plan dated 11/14/18. The plan indicated client A's diagnoses included, but were not limited to, "...Bi-Polar 1 Disorder (psychotic disorder),...Factitious Disorder (when someone deceives others by appearing sick, by purposely getting sick, or self-injury), Mild Intellectual Difficulties, Anti-social and Borderline Personality Disorder, Klinefelter's Syndrome (genetic disorder/extra X chromosome),... Hypothyroidism (underactive thyroid gland), Asthma, Constipation, Urinary Incontinence, Anemia, and Hypertension (high blood pressure)." The review indicated client A's 12/18 MARs/Medication Administration Records which listed the medications he was taking at the time of his visit with his relative (leave of absence 12/15/18 - 1/15/19). Advair Diskus 1 puff by mouth twice daily (asthma), Amitiza 24 mcg./micrograms once daily (constipation), Amoxicillin 500 mg./milligrams three times daily (anti-biotic), Benztropine 2 mg. twice daily EPS/extrapyramidal side effects of medications, cetirizine 10 mg. daily (allergies), desmopressin 1.1 mg. twice daily (urinary incontinence), Divalproex Sod (Sodium) DR/delayed release 500 mg. twice daily (Bipolar), Ferrous Sulf (Sulfate) 325 mg. daily (mineral supplement), Fish Oil 1000 mg. 3 daily (supplement), Lactulose Sol (Solution) 30 ml/milliliters twice daily (constipation),			

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	levothyroxine 88 mcg. daily (hormone), lithium carb (carbonate) ER (extended release) 450 mg. twice daily (Bipolar), loratadine 10 mg. daily (allergies), Midodrine 5 mg. three times daily (for drop in blood pressure when standing/orthostatic hypotension), olanzapine 10 mg. twice daily plus 20 mg. once daily (anti-psychotic), omeprazole 20 mg. daily (stomach acid), oyster calcium 500 mg. with 200 units Vitamin D (supplement), Proair HFA (inhalation aerosol) 2 puffs four times daily (breathing), Strattera 18 mg. once daily (behavior), sulcrafate 1 gm. (gram) twice daily (stomach ulcers), and Vesicare 10 mg. daily (urinary incontinence). Interview with Program Manager/PM #1 on 2/14/19 at 1:36 PM indicated client A had no behaviors which required physical behavior management techniques and had exhibited verbal outbursts which were verbally redirectable prior to his refusals to take his psychotropic medications. PM #1 indicated on 2/14/19 at 1:51 PM, client A was on the path to semi-independent living (leaving the group home) until his being influenced by his relative to stop taking his medications. Confidential interview (CI) #1 stated "we dropped the ball" with client A by allowing him to go home with his relative again after the first visit. The interview indicated the client did well when he took his required medication. The interview indicated it would take time, but if he took his medications, he would be doing as well as he had been before. The interview indicated client A was on track to be earning a placement in a less			

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	restrictive environment prior to his visits in 12/18 and 1/19 with his relative. Confidential interview #2 indicated client A had been doing well working and doing his programming prior to the 12/15/18 to 1/15/19 visit with his relative. The client was exhibiting aggressive behaviors which had not been apparent prior to his visits and refusal to take his psychotropic medications. The agency's "Operation Standard Reporting and Investigating Abuse, Neglect, Exploitation, Mistreatment or Violation of an Individual's Rights" dated 3/08/2018 was reviewed on 2/18/19 at 8:30 AM and indicated the agency prohibited, reported, investigated and implemented corrective measures in regards to abuse/neglect/exploitation/mistreatment of the clients it served. The review of the agency's policy indicated, in part, the following: ..."ResCare strictly prohibits abuse, neglect, exploitation, mistreatment or violation of an Individual's rights....Program Implementation/Intervention: Failure to provide goods and/or services necessary for the individual to avoid physical harm and /or intentional failure to implement a support plan, inappropriate application of intervention, etc. which may result in jeopardy without qualified person notification/review.... Any situation involving weapons, regardless if abuse, neglect, mistreatment or violation of an Individual's rights is suspected, will be immediately investigated. All employees receive training upon hire regarding definitions/causes of different types of, how to identify, prevent, document, remedial action to be taken, timely debriefing following the			

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	incident and how to report abuse, neglect, exploitation, mistreatment or violation of an Individual's rights, as well as what to expect from an investigation. All employees receive this training upon hire and annually, thereafter. Procedures: 1. Any ResCare staff person who suspects an individual is the victim of abuse, neglect, exploitation or mistreatment of an individual should immediately notify the Program Manager, and then complete an Incident Report. The Program Manager will then notify the Executive Director immediately. 2. The Program Manager, or designee, will report the suspected abuse, neglect, exploitation, mistreatment or violations of Individual's rights with 24 hours of the initial report to the appropriate contacts... 3. Any person who is suspected of abuse, neglect, exploitation, mistreatment or violation of an Individual's rights toward an individual will be immediately suspended until the allegation can be fully investigated... 4. The Program Manager will assign an investigative team. A full investigation will be conducted by investigators who have received training from Labor Relations Association and ResCare's internal procedures on investigations. ResCare will not allow for nepotism during the conducting, directing, reviewing or other managerial activity of an investigation into an allegation of abuse, neglect, exploitation or mistreatment, by prohibiting friends and relatives of an alleged perpetrator from engaging in these managerial activities. One of the investigators will complete a detailed investigative case summary			

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	based on witness statements and other evidence collected. The report will be maintained in a confidential, secured file at the office. The investigation file will include the following components: a clear statement indicating why the investigation/review is being conducted along with the nature of the allegations/event (e.g., allegation of neglect, etc.), a clear statement of the event or alleged event in a time-line format including what, where, and when the event happened or is alleged to have happened, Identification by name and title of all involved parties or alleged involved parties including any victim(s) or alleged victim(s), all staff assigned to the victim(s) or alleged victim(s) at the time of the incident, all alleged perpetrators, when indicated; and all actual or potential witnesses to the event or alleged event, signed and dated statements from all involved parties, including all actual and potential witnesses to the event or alleged event, a statement describing all record and other document review associated with the event or alleged event, copies of all records and other documents reviewed that provide evidence supporting the finding of the investigation or review, if there are any discrepancies/conflicts between the evidence gathered, the discrepancy is resolved and/or explained, a determination if rights have been violated, if services and/or care were not provided or were not appropriately provided, if agency policies and/or procedures were not followed, and/or if any federal or state regulations were not followed, a clear statement of substantiation or non-substantiation of any allegation that includes a description/summary of the evidence that result in the finding, a definitive description of all corrective actions developed and implemented and/or to be implemented as a result of the investigation or review, including completion dates for each corrective action, the			

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	signature, name and title of the person completing the investigation and the date the investigation was completed. 5. An investigative peer review committee chosen by the Executive Director will meet to discuss the outcome of the investigation and to ensure that a thorough investigation has been completed. Members of the committee must include at least one of the investigators, the Executive Director or designee, Program Manager, QA representative and a Human Resources representative." This federal tag relates to Complaint #IN00284619. 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 2 sampled clients (A), for 3 of 5 investigations of abuse/neglect/exploitation reviewed, the facility failed to implement corrective action to keep client A from a repeat visit with his relative after a visit in which she did not ensure he took prescribed medications, returned receipts for money spent and returned to the facility as promised. Findings include: The facility's Bureau of Developmental Disabilities Services/BDDS reports, incident reports and investigations were reviewed on 2/14/19 at 11:45 AM and on 2/18/19 at 10:00 AM and indicated the following: 1. A 1/16/19 BDDS report indicated an incident of 1/15/19 at 2:00 PM:	W 0157	1. The Program Manager will ensure the Area Supervisor and Residential Manager retrain direct care staff on the Abuse, Neglect and Exploitation Policy. Failure to follow policy will result in disciplinary action up to and including termination. 2. Upon return of Client A to the facility, a no trespassing/contact order between Client A and Relative to prevent contact was initiated and is being enforced by Clark County Sheriff's Department. The facility administrator petitioned for an Emergency Protective Order that was served to Relative and the order was	03/20/2019

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	"Narrative: [Client A] returned to the home after being on therapeutic leave with his relative, [name] since December 15, 2018. When [name] took [Client A] home with her on 12/15/18 she stated he would not be returning to services. All medications and instructions for administration were provided to her at that time. On 1/15/2019, [Name] contacted [name], program manager and stated she could no longer care for [Client A] and was bringing him back to the group home. When [Client A] returned his relative stated she did not allow him to take any medications for over 20 days and no medications were returned to the home. The nurse completed an assessment of [Client A] and noted involuntary movement she believed to be tardive dyskinesia in nature. It was also noted by the nurse [Client A] had weight loss of 30-35lbs since November 2018 and [Client A] was making nonsensical statements during the assessment. Due to all the concerns, the nurse instructed staff to take [Client A] to the ER (Emergency Room) for an evaluation. Plan to Resolve: [Client A] has been admitted to the behavioral unit at [name] hospital for further evaluation and ResCare remains in contact with the hospital for updates and discharge planning. The team is working with BDDS and APS (Adult Protective Services) to determine what protective measures can be implemented to ensure [Client A]'s safety upon his discharge from the hospital. In addition, the program manager spoke with APS via phone explaining the situation. APS is contacting [name] to inform her she is not to have any contact with [Client A] until she meets with APS." The 1/22/19 investigation regarding the 1/16/19		granted on 3/14/2019. The facility administrator will contact the Clark County Sheriff's Department in the event of attempted contact by Relative with Client A. 3. ResCare received a request for $130 of personal spending money for which no receipts were received. Client A has been reimbursed $130 for the unaccounted funds. The Program Manager Area Supervisor and Residential manager will be re-trained on policy for request of personal funds. Failure to follow the policy will result in disciplinary action up to and including termination. 4. Before any client leaves the Facility, the guardian/family/friends the client will be departing with will be trained on the medical administration standard and will sign a Leave of Absence Form before the client is released to leave. Upon return, the Facility will ensure medication was administered appropriately, if not the client will be assessed by the Nurse, and the incident will be reported to Quality Assurance for submission of an incident report. 5. In the event an emancipated individual's decision puts them at risk of abuse, neglect or exploitation an IDT will be held to	

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	BDDS report indicated: "Factual Findings: [Client A], [name of relative], and [LPN #1] stated [client A] did not take his medications while away with his [relative] for more than 20 days. [Client A]'(s) [name of relative] did not want [client A] to take his medications until he was re-evaluated. [Client A] returned to the home (facility) with significant weight loss and obvious side effects from not taking his medications. Text messages from [name of relative] confirm [client A] was not taking his medications. Conclusion: It is substantiated [client A] did not take his medications for 20 + (plus) days while with his [relative]. It is substantiated [client A]'(s) [relative] stopped his medications because she felt he was being overmedicated." The investigation's Peer Review dated 1/22/19 indicated the following recommendations: "1. Continue to follow agency protocols for therapeutic leaves. 2. APS and Ombudsman assisting with oversight of this case." A Follow-up BDDS Report dated 1/29/19 to the BDDS report of 1/16/19 for incident on 1/15/19 at 2:00 PM indicated: "[Client A] was discharged on 1/21/19 with a discharge diagnosis of Bipolar disorder and Klinefelter syndrome (genetic disorder). His lithium was discontinued. Zyprexa (olanzapine) was reduced from 40 mg QD (once daily) to 30 mg		discuss and determine recommendations. The decision of the IDT will be presented to the Facility Executive Director for final approval. Monitoring of Corrective Action: The Program Manager, Area Supervisor, and Residential Manager will ensure all allegations of abuse, neglect and exploitation are reported to the Quality Assurance department. The Program Manager, Quality Assurance, QIDP, Nursing, Behavior Clinician, Area Supervisor and Residential Manager from the facility will meet weekly for 90 days to review all reports and ensure accurate reporting of abuse, neglect or exploitation. The Residential Manager will review daily documentation to ensure accurate reporting has been completed for 90 days. Administrative staff will complete a minimum of three unannounced visits weekly for 90 days for monitoring. The Residential Manager will ensure all incidents are reported to QA and QA will review all incident reports and follow the abuse, neglect and exploitation policy when applicable. **Persons Responsible: Executive Director, Program Manager, Nurse, QA, Business Manager, Area Supervisor,**	

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	QD, and the Depakote (divalproex sodium) was increased from 500 mg BID (twice daily) to 750 mg BID. Instructions were also given for [client A] to follow up with his psychiatrist within 2 weeks. Staff have been trained on the changes and [client A] will follow up with his psychiatrist on 2/1/2019. In addition, [client A's] [relative] stated she did take him off his medications but did so because she believed he was over medicated. [Client A's] team, including his [relative], BDDS and APS met on 1/29/19 and came to the agreement [client A] will continue in services with ResCare and will take all medications as prescribed by his psychiatrist and PCP (primary care physician). If there are visits with [client A's] [relative], they will be closely monitored to ensure there are no recurring issues." Interview with Program Manager #1 on 2/14/19 at 11:18 AM indicated the hospital where client went after returning to the facility on 1/15/19 was informed to discharge client A only to the facility. Client A's relative had picked him up (1/20/19) without informing the facility from the behavioral unit at the local hospital. Program Manager/PM #1 went to the relative's house and brought client A back to the facility on 1/21/19. PM #1 indicated he had not allowed a home visit on 1/24/19. 2. A 2/12/19 BDDS report indicated an incident of 2/11/19 at 6:30 PM: Narrative: "On 2/3/2019 [client A] went on a home visit with his [relative] [name]. Upon returning to the group home on 2/11/19 it was determined [client A] did not take any of his medications while away from the group home. He has also refused to take any psychotropic medications since his return to the group home."		**QIDP, Residential Manager, and DSPs.**	

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Plan to Resolve:
"[Client A] will be taken to the ER for an evaluation and a valproic acid level (Depakote/divalproex sodium) will be requested. In addition, visits with his [relative] are immediately suspended until the team, including BDDS, APS and the Ombudsman can meet to discuss what protective measures can be implemented to ensure [client A's] safety. In a previous team meeting on 1/29/19 with the [relative], BDDS, and APS it was agreed upon by all that [client A] would continue in services with ResCare and would take all medications as prescribed by his psychiatrist and PCR. That agreement was not honored during the home visit."

Review (2/14/19 2:29 PM) of client A's financial records indicated he had requested personal funds on 2/5/19 to visit his brother out of state while visiting his relative. A check for $130.00 was drawn on client A's personal account dated 2/6/19 and the check was cashed by him on 2/7/19. Client A did not go out of state to visit his brother. He did not bring back any money or receipts when he returned on 2/11/19 from the visit.

3. A 2/13/19 BDDS report indicated an incident on 2/12/19 at 5:00 PM:

Narrative:
"[Client A] was speaking with the nurse prior to going to the ER...and alleged while with his [relative] he was exposed to people using drugs, stated the ResCare nurse and her family were in danger and the group home was at risk of being broken into. [Client A] stated he was fearful to be around his [relative] and the people she was

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	associating with. An officer with the [local county] Sherriff's (sic) department was dispatched to the home and a report was filed...regarding the allegations." Plan to Resolve: "A restraining/no trespassing order was issued against [client A's] [relative] [name] and the access code to the group home has been changed. The team met with BDDS and APS on 2/13/19 and it was agreed there would be no visits allowed with the [relative]. In addition, a court appointed guardian was recommended by APS and the process immediately initiated. As [client A] is currently refusing his psych (psychiatric) medications and refusing to eat normally, he will follow up with his PCP 2/14/19 and a nutritional assessment will be requested. In addition, ResCare has contacted a psych hospital for inpatient medication evaluation and the hospital has agreed criteria is met and they will complete intake and evaluation as soon as a bed becomes available." During observations at the facility on 2/14/19 at 3:28 PM, client A was absent. Area Director/AD #1 indicated on 2/14/19 at 3:45 PM, QIDP/Qualified Intellectual Disability Professional #1 and staff #1 were with client A at the psychiatric hospital awaiting client A's admittance. AD #1 was asked to notify the surveyor if client A was not admitted and returned to the facility on 2/14/19. PM #1 called the surveyor (2/14/19 7:00 PM) and reported client A had not been accepted for inpatient treatment at the psychiatric hospital and was returning to the facility. During observations at the facility on 2/15/19 from 8:28 AM until 9:30 AM, client A was at his living			

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	facility. He was eating scrambled eggs and pears. Client A asked the surveyor if "they put something in them (did facility staff put something unknown in his eggs or pears)?" Client A's upper body leaned to the left and his torso would jerk periodically. The movements were involuntary. Client A indicated he was having difficulty eating but the fruit seemed to go down well. Client C obtained more pears from the refrigerator for client A. Residential Manager #1 offered client A a glass of milk after he stated his eggs might "come back up." Client A indicated he had visited a relative recently and he had not been taking his medications during the visits. Client A went to a local workshop and was observed there from 9:56 AM until 11:17 AM on 2/15/19. Client A was prompted by RM #1 to do a job of putting long plastic tubes into baggies. Client A did an assembly job next which he seemed to enjoy more. Review of client A's record on 2/15/19 at 2:57 PM indicated an ISP/Individual Support Plan dated 11/14/18. The plan indicated client A's diagnoses included, but were not limited to, "...Bi-Polar 1 Disorder (psychotic disorder),...Factitious Disorder (when someone deceives others by appearing sick, by purposely getting sick, or self-injury), Mild Intellectual Difficulties, Anti-social and Borderline Personality Disorder, Klinefelter's Syndrome (genetic disorder/extra X chromosome),... Hypothyroidism (underactive thyroid gland), Asthma, Constipation, Urinary Incontinence, Anemia, and Hypertension (high blood pressure)." The review indicated client A's 12/18 MARs/Medication Administration Records which listed the medications he was taking at the time of his visit with his relative (leave of absence 12/15/18 - 1/15/19). Advair Diskus 1 puff by mouth twice daily			

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	(asthma), Amitiza 24 mcg./micrograms once daily (constipation), Amoxicillin 500 mg./milligrams three times daily (anti-biotic), Benztropine 2 mg. twice daily EPS/extrapyramidal side effects of medications, cetirizine 10 mg. daily (allergies), desmopressin 1.1 mg. twice daily (urinary incontinence), Divalproex Sod (Sodium) DR/delayed release 500 mg. twice daily (Bipolar), Ferrous Sulf (Sulfate) 325 mg. daily (mineral supplement), Fish Oil 1000 mg. 3 daily (supplement), Lactulose Sol (Solution) 30 ml/milliliters twice daily (constipation), levothyroxine 88 mcg. daily (hormone), lithium carb (carbonate) ER (extended release) 450 mg. twice daily (Bipolar), loratadine 10 mg. daily (allergies), Midodrine 5 mg. three times daily (for drop in blood pressure when standing/orthostatic hypotension), olanzapine 10 mg. twice daily plus 20 mg. once daily (anti-psychotic), omeprazole 20 mg. daily (stomach acid), oyster calcium 500 mg. with 200 units Vitamin D (supplement), Proair HFA (inhalation aerosol) 2 puffs four times daily (breathing), Strattera 18 mg. once daily (behavior), sulcrafate 1 gm. (gram) twice daily (stomach ulcers), and Vesicare 10 mg. daily (urinary incontinence). Interview with Program Manager/PM #1 on 2/14/19 at 1:36 PM indicated client A had no behaviors which required physical behavior management techniques and had exhibited verbal			

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	outbursts which were verbally redirectable prior to his refusals to take his psychotropic medications. PM #1 indicated on 2/14/19 at 1:51 PM, client A was on the path to semi-independent living (leaving the group home) until his being influenced by his relative to stop taking his medications. Confidential interview (CI) #1 stated "we dropped the ball" with client A by allowing him to go home with his relative again after the first visit. The interview indicated the client did well when he took his required medication. The interview indicated it would take time but if he took his medication he would be doing as well as he had been before. The interview indicated client A was on track to be earning a placement in a less restrictive environment prior to his visits in 12/18 and 1/19 with his relative. Confidential interview #2 indicated client A had been doing well working and doing his programming prior to the 12/15/18 to 1/15/19 visits with his relative. The client was exhibiting aggressive behaviors which had not been apparent prior to his visit and refusal to take his psychotropic medications. The interview indicated the client should not have been allowed to continue visiting his relative after the first visit. This federal tag relates to Complaint #IN00284619. 9-3-2(a)			