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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G465 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | | X3) DATE SURVEY COMPLETED 08/11/2020 | |
| NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES-ADEPT | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 6025 BUCKSKIN CT INDIANAPOLIS, IN 46250 | | | |
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| W 0000 Bldg. 00 | <p>This visit was for the investigation of complaint #IN00324677. This visit included the COVID-19 focused infection control survey.</p> <p>Complaint #IN00324677: Substantiated. Federal and state deficiency related to the allegation(s) is cited at W154.</p> <p>This visit was in conjunction with the post certification revisit (PCR) to the investigation of complaint #IN00318381 completed on 2/28/20.</p> <p>Dates of Survey: August 4, 5, 6, 7, and 11, 2020.</p> <p>Facility Number: 000979 Provider Number: 15G465 AIMS Number: 100244860</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 8/17/20.</p> | | W 0000 | | | | |
| W 0154 Bldg. 00 | <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 2 of 20 investigations reviewed, the facility failed to complete a thorough investigation into an incident of client behavior involving client A, and an investigation into an allegation of staff abuse involving client A.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental</p> | | W 0154 | <p>CORRECTION: <i>The facility must have evidence that all alleged violations are thoroughly investigated. Specifically: All facility investigations will be completed by trained investigators. The facility must have evidence that all alleged violations are thoroughly investigated. Specifically:</i></p> | | 09/10/2020 | |

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>Disabilities Services) reports and investigations were reviewed on 8/4/2020 at 11:31 AM.</p> <p>1. A BDDS report dated 4/9/20 indicated, "...On the evening of 4/8/20, [client A] wanted to go into the room of his housemates [client D], and [client C] but they didn't want him in their room. [Client A] remained adamant (sic), and threatened to stab them with a pen. Staff redirected [client A] verbally, and he (client A) became physically aggressive, hitting staff, and pushing past staff into his housemates' bedroom. The three individuals (clients A, C, and D) began hitting each other and staff entered the room and separated them. No further contact occurred. Staff continued to redirect [client A] verbally until he calmed down. A body check of all individuals after the incident showed that [client A] had a bruise on the right side of his chin which measured 1/2 a centimeter..."</p> <p>A review of the BDDS report dated 4/9/2020 indicated client A wanted to go into his housemates' (clients C and D) room. The review indicated clients C and D did not want client A in their room. The review indicated client A became physically aggressive and hit staff, pushed past staff and entered client C and D's bedroom. The review indicated the three clients began hitting each other and staff separated them. The review indicated staff redirected client A verbally until he calmed down. The review indicated client A sustained a bruise on his right side of his chin which measured 1/2 a centimeter due to the incident.</p> <p>An IS (Investigative Summary) dated 4/15/20 indicated the following:</p> <p>"...Investigative Summary..."</p> | | | | <p>All facility investigations will be completed by trained investigators. Investigation focus will include but not be limited to interviewing all potential witnesses and comparing documentary and testimonial evidence to identify and clarify discrepancies. Copies of all investigations will be maintained by the Quality Assurance Department to be available for review, as required. The agency's trained investigators will receive additional training regarding investigation timelines and components of a thorough investigation, including weekly face to face training and follow-up with the Quality Assurance Manager. The training will include but not limited to assuring that discrepancies between testimonial and demonstrative evidence are resolved and that investigation findings and conclusions are consistent with the collected evidence. The QIDP Manager will provide weekly follow-up to the QA Manager regarding progress on current investigations.</p> <p>PREVENTION:</p> <p>The QIDP Manager will maintain a tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team, comprised of the Operations Managers, Program</p> | | |

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| | <p>- "...Date(s) of Investigation 4.09 - 4.15.20."</p> <p>- "Introduction."</p> <p>- "On 4.08.20 at 6 pm [client A] (Individual) attempted to enter his housemates (Individuals [client D] & [client C]) bedrooms (sic). Although they asked [client A] not to enter [client A] became verbally aggressive. [Client A] then threatened to stab them with an ink pen and attempted to be physically aggressive with [client D]. [Client D] informed [staff #1] (DSP (Direct Support Professional)) who was in the medication room, that [client A] was upsetting him. [Client A's] one-to-one staff [staff #2] (DSP) verbally redirected him (client A) to the living room. [Staff #1] intervened attempting to speak with [client A] then punched [staff #1] in the face. [Staff #2] and [staff #1] used an agency approved 2-person You're Safe I'm Safe (YSIS) restraint on [client A] for 2 minutes until calm (sic) then released. The supervisor was notified. An investigation was initiated. During the investigation (on 4.13.20) [client B] (Individual) alleged that [staff #2] pulled [client A's] legs resulting in [client A] falling to the ground then [staff #2] witnessed [staff #1] punch [client A]. [Client B] also alleged that [staff #1] (DSP) got on top of [client A] and punched [client A] on his face & body. [Staff #2] and [staff #1] were suspended and a separate investigation was initiated..."</p> <p>- "...Scope of Investigation."</p> <p>- "1) Why did [client A] (Individual) become aggressive and threaten to stab individuals [client D] and [client C]?"</p> | | <p>Managers, Area Supervisors, Nurse Manager, Registered Nurse, Quality Assurance Manager, Quality Assurance Coordinators, and QIDP. The Quality Assurance Manager will meet with his/her QA Department investigators as needed but no less than weekly to review the progress made on all investigations, review incidents and assign responsibility for new incidents/issues requiring investigation. QA team members will be required to attend and sign an in-service documentation at these meetings stating that they are aware of which investigations with which they are required to conduct, as well as the specific components of the investigation for which they are responsible, within the five-business day timeframe. The QA Manager will review the results of these weekly meetings with the Executive Director to assure appropriate follow through occurs. The Quality Assurance Manager and QIDP Manager will develop a training template to assist investigators with developing a sufficient scope to investigations of peer to peer aggression, falls resulting in injury, injuries of unknown origin and elopement. The Quality Assurance Manager and QIDP Manager will spot check investigations to ensure that they are thorough –meeting</p> | | | | |

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| | <p>- "2) Why did that (sic) [client A] (Individual) threatened (sic) to stab [client D]?..."</p> <p>- "...Summary of Interviews..."</p> <p>- "...[staff #2] (DSP) -..."</p> <p>- "...[Client A] wanted to enter their (client C and D's) room and they did not want him to enter."</p> <p>- "He (client A) tried to force himself in the room..."</p> <p>- "...[Staff #1] tried to talk to [client A] but he (client A) immediately punched [staff #1's] left eye."</p> <p>- "We (staff #1 and staff #2) put him (client A) in a restraint...and after 2 minutes we released him..."</p> <p>- "...Were you with [client A] the entire time?"</p> <p>- "Yes..."</p> <p>- "...[Staff #1] (DSP) -."</p> <p>- "[Client D] came to me and said [client A] was trying to come into the (sic) he and [client C's] bedroom."</p> <p>- "I (staff #1) followed him (client D) to the room and [staff #2] was asking [client A] to leave but he refused."</p> <p>- "Sine (sic) he (client A) wouldn't leave we asked the other consumers to go to the living room."</p> <p>- "[Client A] and [client D] were arguing..."</p> | | | | <p>regulatory and operational standards.</p> <p>RESPONSIBLE PARTIES: QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director</p> | | |

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| | <p>-"...[Client A] then punched me in my face."</p> <p>-"[Staff #2] and I quickly put him in a 2-person restraint for 2 minutes..."</p> <p>-"...He (client A) calmed down..."</p> <p>-"...Do you know why he was trying to go in their (client C and D's) room?"</p> <p>-"Sometimes he (client A) goes into their (client C and D's) room to play games."</p> <p>-"[Staff #3] (DSP) -..."</p> <p>-"...I was in the bathroom and I heard the commutation (sic) then I came out into the living room and saw [staff #1] run out to help..."</p> <p>-"...[Client A] hit [staff #1] on his face."</p> <p>-"Do you know why [client A] was trying to go in their (client C and D's) room?"</p> <p>-"I think he (client A) wanted to play but they (clients C and D) did not want him to play."</p> <p>-"Was [staff #2] with [client A]?"</p> <p>-"Before I (staff #3) went into the bathroom he (staff #2) was sitting near the door..."</p> <p>-"...[Client A] (Individual) -..."</p> <p>-"...Why did you go to their bedroom?"</p> <p>-"They (clients C and D) told me to get out then they came and got [staff #1] to get me out of their room."</p> | | | | | | |

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| | <p>- "Was [staff #2] with you the entire time?"</p> <p>- "He (staff #2) was in the front room but checked on me..."</p> <p>- "...Why did you punch [staff #1]?"</p> <p>- "He (staff #1) wanted me to get my vitals done."</p> <p>- "Did staff put you in the restraint?"</p> <p>- "Yeah...and I calmed down."</p> <p>- "[Client D] (Individual) -."</p> <p>- "[Client C] was trying to help [client A] with his staff ([client A] stated he did not like [staff #2])."</p> <p>- "He (client A) was in our room talking c--- about his mom."</p> <p>- "We (clients C and D) told him (client A) we didn't want to hear it and told him to get out."</p> <p>- "[Client C] was trying to help him (client A) with his issues with staff."</p> <p>- "I (client D) went out to get a staff ([staff #1])."</p> <p>- "Where was [staff #2]?"</p> <p>- "I don't know where [staff #2] was at this time."</p> <p>- "I (client D) told [staff #1] what was going on."</p> <p>- "[Staff #1] came out and tried to help..."</p> <p>- "...Where were staff when this occurred?"</p> <p>- "They (staff #1 and staff #2) were in the</p> | | | | | | |

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| | <p>office)."</p> <p>- "I (client D) think [staff #3] was in the bathroom...".</p> <p>- "...[Staff #1] and [staff #2] were in the office...".</p> <p>- "...[Staff #1] came in the living room and [client A] turned and hit him for no reason."</p> <p>- "They ([staff #1] and [staff #2]) restrained him (client A)."</p> <p>- "Did you see staff restrain [client A]?"</p> <p>- "I didn't see what happened."</p> <p>- "They (staff) had us go back to our rooms."</p> <p>- "[Client C] (Individual) -."</p> <p>- "[Client A] was getting angry with his staff ([staff #2]) talking to him and I (client C) told him (client A) he had to respect his staff and it's his (staff #2's) job to be with him (client A)."</p> <p>- "[Client A] was saying to us that he wanted to kill and beat his mom."</p> <p>- "We (clients C and D) told him (client A) we didn't want to hear that and asked him to leave."</p> <p>- "Where was [staff #2] when this happened?"</p> <p>- "He (staff #2) wasn't in the room ([client D] and [client C's] bedroom).</p> <p>- "When we asked [client A] to leave he said he wasn't leaving...".</p> | | | | | | |

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| | <p>-"[Client D] left and told [staff #1] what he (client A) was doing..."</p> <p>-"...He (client A) hit [staff #1]."</p> <p>-"They (staff #1 and #2) put him (client A) in the restraint and he (client A) tried to keep hitting them."</p> <p>-"[Client B] (Individual) -."</p> <p>-"Did you see the incident when [client A] hit [staff #1]?"</p> <p>-"I saw him (client A) hit [staff #1]."</p> <p>-"I saw [staff #1] hit [client A]."</p> <p>-"Who was around when that happened?"</p> <p>-"[Staff #2] was around and he dropped him."</p> <p>-"What does that mean?"</p> <p>-"[Staff #2] pulled [client A's] legs and it made him hit the ground (fall)."</p> <p>-"[Client A] fell to the ground."</p> <p>-"[Staff #1] got on top of [client A] and hit him (client A)."</p> <p>-"Are you sure you saw [staff #1] get onto of (sic) [client A] and not [client A] on top of [staff #1]?"</p> <p>-"Yes..."</p> <p>-"Are you (client B) telling the truth?"</p> | | | | | | |

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| | <p>- "Yes..."</p> <p>- "...Conclusion."</p> <p>- "1) It is substantiated that [client A] (Individual) became aggressive with individuals [client D] and [client C]..."</p> <p>- "...3) It is unsubstantiated that staff followed ResCare Policy and Procedures appropriately. As a result of the allegations made by [client B] (Individual) DSPs [staff #2] and [staff #1] were suspended and a new investigation was initiated..."</p> <p>A review of the IS dated 4/15/20 indicated staff #2 stated client A wanted to enter client C and D's room and they did not want him to enter. The review indicated staff #2 stated client A forced himself into the room. The review indicated clients C and D both made statements indicating client A was already in their bedroom and asked him to leave the room due to inappropriate comments client A was making. The review did not indicate the investigator clarifying the initial scene just prior to the behavior occurring. The review indicated staff #2 stated he was with client A throughout the incident. The review indicated client A stated staff #2 was in the living room but would check on client A. The review indicated statements from client C indicating staff #2 was not with client A at the start of the incident. The review indicated statements from client D indicating staff #2 was in the medication room with staff #1 at the time of the initial incident and not with client A. The review did not indicate the investigator clarified the location of staff #2 (who was assigned to be client A's 1:1 (one-to-one) staff) at the time of the initial incident. The review did not indicate questioning</p> | | | | | | |

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| | <p>or comments regarding the peer to peer physical altercation between clients A, C, and D which was indicated in the BDDS report dated 4/9/20 to have occurred. The review did not indicate questioning or comments regarding how the injury described to have been sustained by client A (described in the BDDS report dated 4/9/20) occurred.</p> <p>2. A BDDS report dated 4/11/2020 indicated, "...On 4/8/20, [client A] engaged in an altercation with his peers (previously reported incident...). At the time of the incident, bruising was noted on [client A's] chin. On 4/9/20, a 2.5-inch bruise developed around his (client A) left eye, and on the afternoon of 4/10/20, [client A] told staff he was not seeing well out of his left eye. Staff notified her supervisor and nurse and transported [client A] to the [name of hospital] Emergency Department for evaluation, per nurse instructions...The attending physician diagnosed [client A] with Pain Around Left Eye, Decreased Vision and Assault...".</p> <p>A review of the BDDS report dated 4/11/20 indicated client A had engaged in an altercation with his peers on 4/8/20 resulting in bruising on client A's chin. The review indicated on 4/9/20 a 2.5-inch bruise developed around client A's left eye. The review indicated on 4/10/20, client A told staff he was seeing well out of his left eye and he was transported to the ER. The review indicated client A was diagnosed at the ER with pain around his left eye, decreased vision, and assault.</p> <p>3. A BDDS report dated 4/14/20 indicated, "...On 4/13/20, during an investigation into an incident of aggressive behavior that occurred on 4/8/20...a housemate alleged that direct support</p> | | | | | | |

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| | <p>staff [staff #2] took [client A] to the floor and that staff [staff #1] hit [client A]..."</p> <p>-An IS dated 4/20/20 indicated the following:</p> <p>- "...Investigative Summary..."</p> <p>- "...Date(s) of Investigation 4.14 - 4.20.20."</p> <p>- "Introduction."</p> <p>- "On 4.13.20 at 4:15 pm during an interview for a separate investigation from 4.08.20 that [client A] (Individual) engaged in an altercation with his peers...[client B] alleged that [staff #2] (DSP) pulled [client A's] legs resulting in [client A] falling to the ground then [staff #2] witnessed [staff #1] punch [client A]. [Client B] also alleged that [staff #1] (DSP) got on top of [client A] and punched [client A] on his face and body..."</p> <p>- "...Scope of Investigation."</p> <p>- "1) Did [staff #1] (DSP) punch [client A] (Individual)?..."</p> <p>- "...3) Did [staff #2] (DSP) pull [client A's] (Individual) legs resulting in his falling onto the ground?"</p> <p>- "4) Did [staff #2] (DSP) witness and fail to report that [staff #1] (DSP) hit [client A] (Individual)?..."</p> <p>- "...Summary of Interviews..."</p> <p>- "...[Client B] (Individual) -."</p> <p>- "I (client B) saw [staff #2] pull [client A's] legs down to the ground and [staff #1] got on top of</p> | | | | | | |

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| | <p>him (client A) and hit him."</p> <p>-"Where was [staff #3]?"</p> <p>-"She (staff #3) was in the backroom with us..."</p> <p>-"...Are you telling the truth?"</p> <p>-"Yes..."</p> <p>-"...[Client A] (Individual) -."</p> <p>-"Please describe the incident on 4.08.20?"</p> <p>-"We ([client A], [client D], and [client C]) were talking."</p> <p>-"They (clients C and D) told me they didn't like what I was saying and told me to leave."</p> <p>-"Where was your one-to-one staff [staff #2] when you were in their bedroom?"</p> <p>-"In the front room."</p> <p>-"[Staff #1] got into it (involved)."</p> <p>-"We ([client A] and [staff #1]) got into a fight."</p> <p>-"Did you hit [staff #1]"</p> <p>-"Yes..."</p> <p>-"...How did you eye get hit?...".</p> <p>-"...The staff did it."</p> <p>-"Was that [staff #1]?"</p> <p>-"[Staff #1]."</p> | | | | | | |

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| | <p>- "Did he (staff #1) hit you all over?"</p> <p>- "Yeah."</p> <p>- "Was [staff #2] around when this happened?"</p> <p>- "Yes."</p> <p>- "Did [staff #2] hit you?"</p> <p>- "No, he (staff #2) was trying to protect me."</p> <p>- "Was [staff #2] telling [staff #1] to stop hitting you?"</p> <p>- "Yeah..."</p> <p>- "...[Client D] (Individual) -..."</p> <p>- "...We told [client A] to get out of our room."</p> <p>- "Who was around when that happened?"</p> <p>- "No one."</p> <p>- "[Staff #2] was there but he wasn't with [client A]."</p> <p>- "I went and got [staff #1] and [staff #1] took [client A] to his room to talk."</p> <p>- "[Client A] stormed out into the living room..."</p> <p>- "...[Staff #1] tried to stop [client A] and asked him to go in the med (medication) room."</p> <p>- "I (client D) went to the garage for a minute then I came back out and walked to my bedroom and I saw [client A] punch [staff #1]."</p> | | | | | | |

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| | <p>- "They (client A and staff #1) were fighting."</p> <p>- "Even when [client A] said he was done [staff #1] kept on going."</p> <p>- "[Staff #1] was punching the [expletive] out of him in the face..."</p> <p>- "...Did you see [staff #2] hit [client A]?"</p> <p>- "I didn't see [staff #2] do anything but he was out there..."</p> <p>- "...[Client C] (Individual) -."</p> <p>- "He (client A) was in the room talking about his parents and we (clients C and D) told him to get out."</p> <p>- "What staff was around?"</p> <p>- "They were all away in the other room..."</p> <p>- "...[Client D] went and got [staff #1]..."</p> <p>- "...We went to the living room."</p> <p>- "[Staff #1] took [client A] away to the med room then [client A] hit him (staff #1)."</p> <p>- "[Client A] hit [staff #1]."</p> <p>- "[Staff #1] tried to put him in a hold."</p> <p>- "[Staff #1] was being aggressive though."</p> <p>- "[Client D] reminded me (client C) that [staff #1] was aggressive."</p> | | | | | | |

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| | <p>- "What was [staff #1] doing?"</p> <p>- "He (staff #1) punched [client A] everywhere..."</p> <p>- "...Where did this take place?"</p> <p>- "We were in the hallway."</p> <p>- "Where was [staff #2]?"</p> <p>- "I (client C) don't know where he (staff #2) was."</p> <p>- "He (staff #2) showed up after the incident..."</p> <p>- "...[Staff #1] lost it and was going crazy on [client A]..."</p> <p>- "...[Client E] (Individual) -."</p> <p>- "Did you see [staff #1] hit [client A]?"</p> <p>- "Yes..."</p> <p>- "...Did [staff #1] hit [client A] in the face?"</p> <p>- "Yes..."</p> <p>- "Did [staff #2] hit [client A]?"</p> <p>- "No..."</p> <p>- "Did anyone tell you to like and say [staff #1] hit [client A]?"</p> <p>- "Nobody told me..."</p> <p>- "...Are you telling the truth?"</p> <p>- "Yes..."</p> | | | | | | |

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| | <p>- "...[Staff #2] (DSP) -."</p> <p>- "They (clients A, C, and D) were in their rooms playing games..."</p> <p>- "[Client A] was in their room playing."</p> <p>- "Did you hear what they were talking about?"</p> <p>- "I don't know what they were discussing..."</p> <p>- "...[Client D] stood and went out."</p> <p>- "I (staff #2) didn't know he went to get [staff #1]..."</p> <p>- "...[Staff #1] said we should all go to the living room to discuss."</p> <p>- "[Client A] turned back and punched [staff #1] on the left eye..."</p> <p>- "...I (staff #2) grab (sic) his (client A's) hand and [staff #1] held on hand..."</p> <p>- "...How was [client A] moving around (sic)."</p> <p>- "He (client A) was yelling..."</p> <p>- "Did anyone see you do the restraint?"</p> <p>- "When he (client A) was yelling [staff #3] came and got them (other clients) to get them away."</p> <p>- "Only [staff #1] and I (staff #2) were (sic) during the restraint."</p> <p>- "Did [staff #1] ever punch [client A]?"</p> <p>- "No..."</p> | | | | | | |

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| | <p>- "Did you lock your arm around his (client A's) arm or only hold his (client A's) hand?"</p> <p>- "I (staff #2) held his hand."</p> <p>- "We went down (sitting down)."</p> <p>- "We all fell to the floor because [client A] was moving around."</p> <p>- "We stood up and sat in the chair, we never dragged him (client A)...".</p> <p>- "What about [staff #1]?"</p> <p>- "[Staff #1] held his hand."</p> <p>- "Did anyone get on top of [client A] to hold him down?"</p> <p>- "No."</p> <p>- "We held his hand for about 3 minutes and sat on the chairs then let him go..."</p> <p>- "...Was [client A's] eye or ear swollen?"</p> <p>- "When he hit the floor, he hit his face on the floor."</p> <p>- "Again, how did he fall?"</p> <p>- "When he held his hand, he was (sic)."</p> <p>- "Did you or [staff #1] fall?"</p> <p>- "Yes."</p> <p>- "I fell on my bottom."</p> | | | | | | |

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| | <p>- "What about [staff #1]?"</p> <p>- "Same thing (he fell on his bottom)..."</p> <p>- "...Did you ever pull his legs or drag him?"</p> <p>- "No."</p> <p>"I never pull or drag him..."</p> <p>- "...[Staff #1] (DSP) -."</p> <p>- "Please describe the incident on 4.08.20?"</p> <p>- "I [staff #1] was in the med room calling all the individuals in to take their vitals."</p> <p>- "[Client D] came and asked me to please tell [client A] to leave he and [client C's] bedroom..."</p> <p>- "...I met with [staff #2] at the entrance of their ([client D & [client C's]) bedroom and [staff #2] was telling [client A] to leave their room."</p> <p>- "I (staff #1) asked [client A] to leave their room but [client A] did not want to leave."</p> <p>- "I talked to the other guys ([client D] & [client C]) and told them since (client A) does not want to leave their room then for them to come with me to the med room and wait..."</p> <p>- "...For no reason, between a few seconds of walking, he (client A) hit me."</p> <p>- "I didn't even know where the blow (punch) came from..."</p> <p>- "...The other staff ([staff #2]) held [client A's]</p> | | | | | | |

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| | <p>hand as I was holding my eye."</p> <p>-"When I heard [staff #2] struggling with [client A] I held [client A's] other hand..."</p> <p>-"...We all fell down..."</p> <p>-"...Did anyone interlock their arm with [client A]?"</p> <p>-"No, we just held his (client A's) hand."</p> <p>-"How did everyone fall?"</p> <p>-"I (staff #1) held onto [client A] with two hands on his right hand and [staff #2] held him with two hands with (sic) his (client A's) left hand."</p> <p>-"I fell onto my right hand on the floor."</p> <p>-"[Client A] fell on his stomach and face..."</p> <p>-"...Factual Findings."</p> <p>-"Order of Events and Story Discrepancies -..."</p> <p>-"...[Client A] went into [client D] and [client C's] bedroom which is directly across from his (client A's bedroom)."</p> <p>-"...[Staff #3] stated she saw [staff #2] sitting at [client A's] bedroom door prior to her going into the bathroom."</p> <p>-"[Client D], [client C], and [client A] stated [staff #2] was not outside the door while [client A] was in the bedroom."</p> <p>-"[Client A] was making verbally aggressive</p> | | | | | | |

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| | <p>comments about his (client A's) parents and mother."</p> <p>-"[Client D] and [client C] did not like that and told him to leave."</p> <p>-"[Client A] became upset and began displaying verbally aggressive behaviors with them."</p> <p>-"[Client D] stated [staff #2] was not around and he (client D) went to the med room to get [staff #1] to help."</p> <p>-"[Staff #1] stated [staff #2] was at the bedroom and was telling [client A] to leave their bedroom..."</p> <p>-"....[Client A] then began to follow and walk behind [staff #1]."</p> <p>-"[Client A] then punched [staff #1] in the eye..."</p> <p>-"...[Staff #2] grabbed and held [client A's] left hand."</p> <p>-"[Staff #1] heard [staff #2] struggling with [client A] so [staff #1] then grabbed and held [client A's] right hand."</p> <p>-"[Staff #1] also held [client A's] other hand..."</p> <p>-"...[Client C] stated [staff #2] was not around during the incident..."</p> <p>-"...After [staff #1] and [staff #2] held onto [client A's] hand they all fell onto the floor due to [client A] moving around a lot."</p> <p>-"...[Client A] fell onto his stomach and hit his face on the floor. There were (sic) no visible</p> | | | | | | |

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| | <p>bruising or injury observed that night..."</p> <p>-"...[Client A's] eye injury was not visible until the morning of 4/09 and he was taken to the hospital on 4/10."</p> <p>-"[Client B] stated he saw [staff #2] pull [client A's] legs down to the ground and [staff #1] got on top of him and hit him."</p> <p>-"[Client A] never stated anyone pulled his legs making him fall..."</p> <p>-"...Conclusion."</p> <p>-"1) It is unsubstantiated that [staff #1] (DSP) punched [client A] (Individual)..."</p> <p>-"3) It is unsubstantiated that [staff #2] (DSP) pulled [client A's] (Individual) legs resulting in his falling onto the ground."</p> <p>-"4) It is unsubstantiated that [staff #2] (DSP) witnessed and failed to report that [staff #1] (DSP) hit [client A] (Individual)."</p> <p>-"5) It is substantiated that [staff #2] (DSP) failed to follow ResCare Policy and Procedures appropriately as it is believed at some point when [client A] was in [client D] and [client C's] bedroom that he (staff #2) was not sitting outside the door as [client A's] one-on-one staff..."</p> <p>A review of the IS dated 4/20/20 indicated during an interview for a separate investigation client B alleged staff #2 pulled client A's legs resulting in client A falling. The review indicated client B alleged staff #2 witnessed staff #1 punch client A. The review indicated client B alleged staff #1</p> | | | | | | |

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| | <p>got on top of client A and punched client A on his face and body. The review indicated clients A, B, C, D, and E all stated staff #1 hit client A. The review indicated staff #1 and staff #2 denied staff #1 hit client A. The review indicated staff #2 stated client A was initially in client C and D's bedroom playing games and clients C and D asked client A to leave their room due to inappropriate comments client A was making . The review indicated the statement from staff #2 made during the investigation dated 4/20/20 regarding where client A was prior to the behavior occurring (stated client A was in client C and D's room playing games) was different than the statement staff #2 made during the original investigation (investigation completed 4/15/20) where staff #2 stated client A wanted to go into clients C and D's room but they did not want him to go into their room which caused the behavior. The review indicated the investigator failed to clarify the discrepancy as to the location of client A just prior to the behavior occurring and why the behavior originally occurred. The review did not indicate any questions or comments regarding any physical altercation actually occurring between clients A, C, and D. The review indicated (under factual findings) there was no visible bruising or injuries observed on the night of the incident, compared to the original BDDS report filed regarding the initial incident on 4/8/20 (filed on 4/9/20) which indicated client A sustained a bruise on the right side of his chin which measured 1/2 a centimeter.</p> <p>QAC (Quality Assurance Coordinator) #1 was interviewed on 8/5/20 at 11:47 AM. QAC #1 was asked about the discrepancies regarding staff #2's statements regarding the location of client A just before the behavior occurred. QAC #1</p> | | | | | | |

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| | <p>indicated more questions should have been asked to clarify the discrepancy. QAC #1 was asked why no questions or comments regarding a physical altercation between clients A, C, and D (which was indicated in the BDDS report dated 4/9/20) were addressed in the investigations. QAC #1 indicated there should have been questions regarding the physical altercation which was described in the BDDS report.</p> <p>QIDPM (Qualified Intellectual Disabilities Professional Manager) #1 was interviewed on 8/6/20 at 12:08 PM. QIDPM #1 was asked if the facility had a BDDS report dated 4/9/20 involving a peer aggression incident (involving clients A, C, and D) which indicated client A wanted to go into clients C and D's room, but clients C and D did not want him in their room, resulting in client A becoming physically aggressive. QIDPM #1 stated, "Yes." QIDPM #1 was asked if the BDDS report dated 4/9/20 indicated the three clients (clients A, C, and D) began hitting each other and staff entered the room and separated them. QIDPM #1 stated, "Yes." QIDPM #1 was asked if the BDDS report dated 4/9/20 indicated client A sustained an injury to his chin and how the injury occurred. QIDPM #1 stated, "The report does indicate injury, but not specifically how the injury occurred." QIDPM #1 was asked why the BDDS report dated 4/9/20 did not indicate client A was put into a containment hold. QIDPM #1 stated, "The report was submitted before we discovered he was put in a hold." QIDPM #1 was asked if the investigation (completed 4/9 through 4/15) into the peer aggression incident which occurred on 4/8/20 indicated staff #2 stating client A wanted to enter client C and D's room and they did not want him to enter. QIDPM #1 stated, "Yes." QIDPM #1 was asked if the investigation (4/9</p> | | | | | | |

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| | through 4/15 investigation) indicated from statements made by clients C and D that client A was already in their room talking and due to comments he (client A) was making they (clients C and D) asked him (client A) to leave the room. QIDPM #1 stated, "Yes." QIDPM #1 was asked if an allegation was made during the investigation of the peer aggression incident of staff abuse. QIDPM #1 stated, "Yes." QIDPM #1 was asked if during the investigation into the allegation of staff abuse (investigation completed between 4/14 through 4/20) was there a statement made from staff #2 indicating client A was in client C and D's room playing games prior to the peer aggression incident occurring. QIDPM #1 stated, "Yes." QIDPM #1 was asked if, during either of the investigations, did the investigator resolve why the statements made by the same staff about the initial scene leading to the client behavior differed. QIDPM #1 stated, "It is not noted in the summary. They should have looked into that." QIDPM #1 was asked if the investigator looked into the peer to peer physical aggression that was indicated in the BDDS report dated 4/9/20 during either of the investigations. QIDPM #1 stated, "No, I'm not seeing it. That should have been looked in to." QIDPM #1 was asked if both investigations indicated interviewees stating different locations for staff #2 or not seeing staff #2 with client A. QIDPM #1 stated, "Yes." QIDPM #1 was asked about how the investigator resolved the discrepancy regarding the location of staff #2. QIDPM #1 stated, "The summary does not indicate how those discrepancies were resolved." QIDPM #1 was asked if any other injuries were sustained as a result of the client aggression incident (outside of the indicated bruise on the right side of client A's chin). QIDPM #1 indicated there was also bruising around the left eye discovered the day after the | | | | | | |

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| W 0455 Bldg. 00 | <p>initial incident. QIDPM #1 was asked how the facility determined these injuries occurred. QIDPM #1 stated, "The containment hold and the fall from the hold." QIDPM #1 was asked if the investigation into the allegation of staff abuse indicated multiple interviewees stating staff #1 hit client A. QIDPM #1 indicated there were 4 interviewees who stated the hitting occurred. QIDPM #1 was asked about how, with the discrepancies regarding; the initial scene leading to the initial incident, the location of staff during the incident, the allegation made regarding staff abuse, and how the injuries potentially occurred, was the investigator able to substantiate how the injuries occurred, and unsubstantiate that the allegation of staff abuse did not occur. QIDPM #1 stated, "The investigation does not show how that conclusion was drawn." QIDPM #1 was asked if the investigations into the client aggression behavior and allegation of staff abuse were completed thoroughly. QIDPM #1 stated, "No."</p> <p>This federal tag relates to complaint #IN00324677.</p> <p>9-3-2(a)</p> <p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview for 3 of 3 sampled clients (A, B, and C), plus 5 additional clients (clients D, E, F, G, and H), the facility failed to ensure staff working in the home implemented proactive/preventative COVID-19 infection control measures.</p> | | W 0455 | <p>W 455 CORRECTION: <i>There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Specifically, all facility staff will be</i></p> | | 09/10/2020 | |

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| | <p>Findings include:</p> <p>Observation was conducted at the group home on 8/4/20 from 8:05 AM through 10:24 AM. Upon entrance into the group home at 8:05 AM, staff #4 greeted the surveyor and asked him to complete the screening process. Staff #4 pointed to a cabinet in the entrance way corner which had some of the group home's binders and a small bag with a digital thermometer, and the visitor log. After staff #4 pointed towards the cabinet, staff #4 left to assist client F, leaving the surveyor to complete the screening process with no staff monitoring.</p> <p>The facility's Pandemic COVID-19 form dated 6/29/20 was reviewed on 8/6/20 at 10:58 AM. The Pandemic COVID-19 form indicated the following:</p> <p>- "ResCare [name of City] Pandemic COVID-19."</p> <p>- "Revised: 06/29/2020..."</p> <p>- "...Prevention."</p> <p>- "In an effort to protect our individuals and employees from the potential spread of the COVID-19, we are restricting all visitor access to all agency locations until the National State of Emergency is lifted..."</p> <p>- "...In order to ensure infection prevention, the agency will implement the following:."</p> <p>- "Each shift will ensure the following occurs."</p> <p>- "Oncoming staff or mandatory visitors to the home...will need to wash their hands when coming into the home."</p> | | | | <p>retrained regarding implementation of proactive and preventative COVID-19 infection control measures, including but not limited to assuring visitors are properly screened prior to entry into the facility.</p> <p>PREVENTION: A management staff will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assure appropriate implementation of proactive and preventative COVID-19 infection control measures. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Area Supervisors, Nurse Manager and Assistant Nurse Manager) will conduct twice weekly administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios. This monitoring will occur face to face and via video conferencing platforms due to the need to contain the spread of COVID-19. After 30 days, administrative monitoring will occur no less than weekly until all staff demonstrate competence. After this period of</p> | | |

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| | <p>- "Oncoming staff or mandatory visitors in the home...will get a temperature check upon entering the home. Anyone with a temp (temperature) of 100.4 or (sic) more will be sent home or asked to leave."</p> <p>- "If someone is discovered to have a temperature 100.4 or more than this will be noted on the employee or visitor's screening tool..."</p> <p>RM (Resident Manager) #1 was interviewed on 8/4/20 at 8:40 AM. RM #1 was asked if all staff working in the home had completed the facility's COVID-19 protocol/procedures training. RM #1 stated, "Yes." RM #1 was asked about the visitor screening process. RM #1 indicated any visitor to the group home is supposed to have their temperature checked, complete a symptoms check-list form, and sign in to the visitor log. RM #1 was asked if a visitor to the group home is supposed to complete all of these items independently without any staff around to monitor. RM #1 indicated staff should monitor the visitor throughout the screening process and ensure the visitor is not presenting with any symptoms and the visitor's temperature is not too high.</p> <p>QIDPM (Qualified Intellectual Disabilities Professional Manager) #1 was interviewed on 8/6/20 at 12:08 PM. QIDPM #1 was about staff being trained on the facility's COVID-19 protocols/procedures and who completed the trainings. QIDPM #1 indicated all staff were trained by either the Area Supervisor or Resident Manager. QIDPM #1 was asked if the group home was allowing visitors. QIDPM #1 stated, "On a case by case basis, we are screening them and encouraging them to meet outside with</p> | | <p>enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility.</p> <p>Administrative Monitoring is defined as follows:</p> <ul style="list-style-type: none"> · The role of the administrative monitor is not simply to observe & Report. · When opportunities for training are observed, the monitor must step in and provide the training and document it. · If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports. · Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. · Review all relevant documentation, providing documented coaching and training as needed <p>Administrative support at the home will include but not limited to assuring appropriate implementation of proactive and preventative COVID-19 infection control measures.</p> <p>RESPONSIBLE PARTIES: QIDP, Residential Manager, Direct Support Staff, Operations Team, Regional Director</p> | | | | |

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| | <p>appropriate social distancing." QIDPM #1 was asked about the screening process for visitors. QIDPM #1 stated, "Staff should screen visitors. They should ask questions on the screening form and observe visitors taking their temperature and ensure screening form is completed appropriately. If they pass the screening they are permitted, if they do not pass they are not permitted." QIDPM #1 was asked if a visitor to the group home should be asked to complete the screening process by themselves without a current staff in the home observing the process. QIDPM #1 stated, "No because they could have a temperature or a symptom and not be known."</p> <p>9-3-7(a)</p> | | | | | | |