STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G465	A. BUILDING 00 B. WING	02/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES-ADEPT	6025 BUCKSKIN CT INDIANAPOLIS, IN 46250

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W 0000 Bldg. 00	This visit was for the investigation of complaint #IN00318381. Complaint #IN00318381: Substantiated, Federal and state deficiencies related to the allegation are cited at W102, W104, W122, W149, W154, and W157. Unrelated deficiencies cited. This visit was in conjunction with the post certification revisit (PCR) to the PCR completed on 1/7/20, to the investigation of complaint #IN00309404 completed on 11/7/19. Dates of Survey: February 21, 24, 25, 26, and 28, 2020. Facility Number: 000979 Provider Number: 15G466 AIMS Number: 100244860 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/10/20.	W 0000		
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on record review and interview, the facility neglected to meet the Condition of Participation: Governing Body for 3 of 3 sampled clients (clients A, B, and C), plus 3 additional clients (clients D, F, and G). The governing body neglected to exercise	W 0102	**CORRECTION:** *The facility must ensure that specific governing body and management requirements are met.* Specifically:	03/29/2020

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	general policy, budget, and operating direction over the facility to prevent multiple elopements involving client A, to ensure client A's protective measures were being followed, to ensure the immediate notification of supervisors/administration following a police visit, while they were conducting an investigation, to the group home while clients B, C D, F, and G were sleeping, to ensure sufficient staff were present to prevent the elopement of client F, to ensure the completion of an investigation into the elopement of client F, and to ensure client F's BSP (Behavior Support Plan) was followed as written. Findings include: 1. The governing body failed to exercise general policy, budget and operating direction to prevent multiple elopements involving client A, to ensure client A's protective measures were being followed, to ensure the immediate notification of supervisors/administration following a police visit, while they were conducting an investigation, to the group home, to ensure sufficient staff were present to prevent the elopement of client F, to ensure the completion of an investigation into the elopement of client F, and to ensure client F's BSP was followed as written. Please see W104. 2. The governing body failed to exercise operating direction over the facility to meet the Condition of Participation: Client Protections for 3 of 3 sampled clients (clients A, B and C) plus 3 additional clients (clients D, F, and G). The governing body failed to follow the facility's policy and procedure regarding the prevention multiple elopements involving client A, to ensure client A's protective measures were being followed, to ensure the immediate notification of supervisors/administration following a police		Facility staff will be retrained regarding required reporting criteria and timelines. The governing body has hired an additional Quality Assurance Coordinator, who will be assigned to complete investigations at the facility. The addition of the new position will reduce the overall workload for each investigator by 20%, allowing for increased efficiency and attention to detail. 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, including but not limited to interview techniques, gathering and analysis of documentary evidence. The emphasis of this training will be development of appropriate scope and conclusions, including the need to expand the scope of investigations must be expanded when additional	

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	visit, while they were conducting an investigation, to the group home while clients B, C, D, F, and G were sleeping, to ensure sufficient staff were present to prevent the elopement of client F, to ensure the completion of an investigation into the elopement of client F, and to ensure client F's BSP was followed as written. Please see W122. This federal tag relates to complaint #IN00318381. 9-3-1(a)		allegation(s) emerge. The QIDP Manager will provide weekly follow-up to the QA Manager regarding progress on current investigations. Client F no longer lives at the facility. All facility direct support and supervisory staff will be retrained on proper implementation of each client's Behavior Support Plan, including client A's enhanced supervision protocols. Additionally, when clients are visiting other ICF or Waiver homes, pending transition, the facility will provide training to direct support staff at the location of the visit to facilitate proper implementation of behavior supports. The Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than two staff on duty between 24/7, with additional staffing resources to be made available, based on acute need. Additionally, when clients are visiting other ICF or Waiver homes, pending transition, the facility will provide direct support staff at the location of the visit to assure required staffing ratios are in place. When direct support personnel are unavailable to provide coverage as described above, salaried supervisory staff will fill in, providing direct support as needed. **PREVENTION:**	

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			The Quality Assurance Manager and the QIDP Manager will carefully review all incidents reported by the facility and outside entities, to assure that allegations and other required incidents are reported to the Bureau of Developmental Disabilities Services as required by state law. Each day, QIDP Manager or designee will compile a list of incidents requiring reports to the Bureau of Developmental Disabilities Services, and distribute the list to administrative staff (including the Quality Assurance Manager, Program Managers, Quality Assurance Coordinators, Operations Manager, Area Supervisors, QIDP, Nurse Manager and Assistant Nurse Manager) for review and revision, as needed. The QIDP Manager or designee will assign reporting responsibilities daily. Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent via electronic fax directly to administrative staff. The Quality Assurance Manager and the QIDP Manager will coordinate and follow-up with the Quality Assurance Coordinators, QIDPs and other staff responsible for reporting to outside agencies, to assure incidents are reported to state agencies as required.	

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			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 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	

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			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 regulatory and operational standards. When incidents occur, The QIDP Manager will coordinate with the trained investigator and QIDP, through the investigation and corrective measure implementation process, to assure staff are trained to implement protective measures as written. Each evening for the next 90 days, the Residential Manager will submit a list of scheduled staff with their assigned hours, for the following day. The list will be reviewed by the Area Supervisor, Program Manager, Operations Manager, Quality Assurance Manager and QIDP Manager. Administrative staff will direct the team, making adjustments as needed. After 90 days, the Operations Manager and Quality Assurance Manager will determine the level of monitoring necessary to assure appropriate coverage. The Residential Manager will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor implementation of behavior supports as written.	

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			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 daily administrative monitoring during varied shifts/times. After 30 days, administrative monitoring will occur no less than weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Administrative Monitoring is defined as follows: · 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	

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			documentation, providing documented coaching and training as needed Administrative support at the home will include · Assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to assuring implementation of protective measures and Behavior Support Plans as written. · Assuring adequate direct support staff are on duty to meet the needs of all clients. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
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 3 of 3 sampled clients (clients A, B, and C), plus 3 additional clients (clients D, F, and G), the governing body failed to exercise general policy, budget and operating direction over the facility to prevent multiple elopements involving client A, to ensure client A's protective measures were being followed, to ensure the immediate notification of supervisors/administration following a police visit, while they were conducting an investigation, to the group home while clients B, C, D, F, and G were sleeping, to ensure sufficient staff were present to prevent the elopement of client F, to ensure the completion of an investigation into the	W 0104	**CORRECTION:** *The governing body must exercise general policy, budget, and operating direction over the facility.* Specifically, Facility staff will be retrained regarding required reporting criteria and timelines. The governing body has hired an additional Quality Assurance Coordinator, who will be assigned to complete investigations at the facility. The addition of the new position will reduce the overall	03/29/2020

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	elopement of client F, and to ensure client F's BSP (Behavior Support Plan) was followed as written. Findings include: 1. The governing body neglected to implement general policy, budget, and operating direction over the facility to prevent multiple elopements involving client A, to ensure client A's protective measures were being followed, to ensure the immediate notification of supervisors/administration following a police visit, while they were conducting an investigation, to the group home while clients B, C, D, F, and G were sleeping, to ensure sufficient staff were present to prevent the elopement of client F, to ensure the completion of an investigation into the elopement of client F, and to ensure client F's BSP was followed as written. Please see W149. 2. The governing body neglected to implement general policy, budget, and operating direction over the facility to ensure completion of a thorough investigation into two elopements of client A, and to ensure completion of an investigation into the elopement of client F. Please see W154. 3. The governing body neglected to implement general policy, budget, and operating direction over the facility to ensure client A's protective measures were being followed. Please see W157. This federal tag relates to complaint #IN00318381. 9-3-1(a)		workload for each investigator by 20%, allowing for increased efficiency and attention to detail. 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, including but not limited to interview techniques, gathering and analysis of documentary evidence. The emphasis of this training will be development of appropriate scope and conclusions, including the need to expand the scope of investigations must be expanded when additional allegation(s) emerge. The QIDP Manager will provide weekly follow-up to the QA Manager regarding progress on current investigations. Client F no longer lives at the facility. All facility direct support and supervisory staff will be retrained on proper implementation	

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			of each client's Behavior Support Plan, including client A's enhanced supervision protocols. Additionally, when clients are visiting other ICF or Waiver homes, pending transition, the facility will provide training to direct support staff at the location of the visit to facilitate proper implementation of behavior supports. The Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than two staff on duty between 24/7, with additional staffing resources to be made available, based on acute need. Additionally, when clients are visiting other ICF or Waiver homes, pending transition, the facility will provide direct support staff at the location of the visit to assure required staffing ratios are in place. When direct support personnel are unavailable to provide coverage as described above, salaried supervisory staff will fill in, providing direct support as needed. **PREVENTION:** The Quality Assurance Manager and the QIDP Manager will carefully review all incidents reported by the facility and outside entities, to assure that allegations and other required incidents are reported to the Bureau of Developmental Disabilities Services as required by state law.	

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			Each day, QIDP Manager or designee will compile a list of incidents requiring reports to the Bureau of Developmental Disabilities Services, and distribute the list to administrative staff (including the Quality Assurance Manager, Program Managers, Quality Assurance Coordinators, Operations Manager, Area Supervisors, QIDP, Nurse Manager and Assistant Nurse Manager) for review and revision, as needed. The QIDP Manager or designee will assign reporting responsibilities daily. Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent via electronic fax directly to administrative staff. The Quality Assurance Manager and the QIDP Manager will coordinate and follow-up with the Quality Assurance Coordinators, QIDPs and other staff responsible for reporting to outside agencies, to assure incidents are reported to state agencies as required. 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 Managers, Area	

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			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 regulatory and operational standards.	

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			When incidents occur, The QIDP Manager will coordinate with the trained investigator and QIDP, through the investigation and corrective measure implementation process, to assure staff are trained to implement protective measures as written. Each evening for the next 90 days, the Residential Manager will submit a list of scheduled staff with their assigned hours, for the following day. The list will be reviewed by the Area Supervisor, Program Manager, Operations Manager, Quality Assurance Manager and QIDP Manager. Administrative staff will direct the team, making adjustments as needed. After 90 days, the Operations Manager and Quality Assurance Manager will determine the level of monitoring necessary to assure appropriate coverage. The Residential Manager will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor implementation of behavior supports as written. 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	

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			conduct daily administrative monitoring during varied shifts/times. After 30 days, administrative monitoring will occur no less than weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Administrative Monitoring is defined as follows: · 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 Administrative support at the home will include · Assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to	

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			assuring implementation of protective measures and Behavior Support Plans as written. · Assuring adequate direct support staff are on duty to meet the needs of all clients. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview for 3 of 3 sampled clients (clients A, B, and C) plus 3 additional clients (clients D, F, and G), facility failed to meet the Condition of Participation: Client Protections. The facility neglected to follow the facility's policy and procedure regarding the prevention of multiple elopements involving client A, to ensure client A's protective measures were being followed, to ensure the immediate notification of supervisors/administration following a police visit, while they were conducting an investigation, to the group home while clients B, C, D, F, and G were sleeping, to ensure sufficient staff were present to prevent the elopement of client F, to ensure the completion of an investigation into the elopement of client F, and to ensure client F's BSP (Behavior Support Plan) was followed as written. Findings include: 1. The facility neglected to implement its policy and procedures to prevent multiple elopements involving client A, to ensure client A's protective	W 0122	**CORRECTION:** *The facility must ensure that specific client protections requirements are met.* Specifically, the governing body facilitated the following: Facility staff will be retrained regarding required reporting criteria and timelines. The governing body has hired an additional Quality Assurance Coordinator, who will be assigned to complete investigations at the facility. The addition of the new position will reduce the overall workload for each investigator by 20%, allowing for increased efficiency and attention to detail. 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	03/29/2020

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	measures were being followed, to ensure the immediate notification of supervisors/administration following a police visit, while conducting an investigation, to the group home while clients B, C, D, F, and G were sleeping, to ensure sufficient staff were present to prevent the elopement of client F, to ensure the completion of an investigation into the elopement of client F, and to ensure client F's BSP was followed as written. Please see W149. 2. The facility failed to complete a thorough investigation into two elopements of client A, and failed to complete an investigation into the elopement of client F. Please see W154. 3. The facility failed to ensure client A's protective measures were being followed. Please see W157. This federal tag relates to complaint #IN00318381. 9-3-2(a)		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, including but not limited to interview techniques, gathering and analysis of documentary evidence. The emphasis of this training will be development of appropriate scope and conclusions, including the need to expand the scope of investigations must be expanded when additional allegation(s) emerge. The QIDP Manager will provide weekly follow-up to the QA Manager regarding progress on current investigations. Client F no longer lives at the facility. All facility direct support and supervisory staff will be retrained on proper implementation of each client's Behavior Support Plan, including client A's enhanced supervision protocols. Additionally, when clients are visiting other ICF or Waiver homes, pending transition, the facility will provide training to direct support staff at the location of the visit to facilitate proper	

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			implementation of behavior supports. The Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than two staff on duty between 24/7, with additional staffing resources to be made available, based on acute need. Additionally, when clients are visiting other ICF or Waiver homes, pending transition, the facility will provide direct support staff at the location of the visit to assure required staffing ratios are in place. When direct support personnel are unavailable to provide coverage as described above, salaried supervisory staff will fill in, providing direct support as needed. **PREVENTION:** The Quality Assurance Manager and the QIDP Manager will carefully review all incidents reported by the facility and outside entities, to assure that allegations and other required incidents are reported to the Bureau of Developmental Disabilities Services as required by state law. Each day, QIDP Manager or designee will compile a list of incidents requiring reports to the Bureau of Developmental Disabilities Services, and distribute the list to administrative staff (including the Quality Assurance Manager, Program Managers, Quality Assurance	

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			Coordinators, Operations Manager, Area Supervisors, QIDP, Nurse Manager and Assistant Nurse Manager) for review and revision, as needed. The QIDP Manager or designee will assign reporting responsibilities daily. Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent via electronic fax directly to administrative staff. The Quality Assurance Manager and the QIDP Manager will coordinate and follow-up with the Quality Assurance Coordinators, QIDPs and other staff responsible for reporting to outside agencies, to assure incidents are reported to state agencies as required. 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 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	

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			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 regulatory and operational standards. When incidents occur, The QIDP Manager will coordinate with the trained investigator and QIDP, through the investigation and corrective measure implementation process, to assure staff are trained to implement protective measures as written. Each evening for the next 90 days,	

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			the Residential Manager will submit a list of scheduled staff with their assigned hours, for the following day. The list will be reviewed by the Area Supervisor, Program Manager, Operations Manager, Quality Assurance Manager and QIDP Manager. Administrative staff will direct the team, making adjustments as needed. After 90 days, the Operations Manager and Quality Assurance Manager will determine the level of monitoring necessary to assure appropriate coverage. The Residential Manager will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor implementation of behavior supports as written. 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 daily administrative monitoring during varied shifts/times. After 30 days, administrative monitoring will occur no less than weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director	

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			and Regional Director will determine the level of ongoing support needed at the facility. Administrative Monitoring is defined as follows: · 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 Administrative support at the home will include · Assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to assuring implementation of protective measures and Behavior Support Plans as written. Assuring adequate direct support staff are on duty to meet the needs of all clients.	
W 0149	483.420(d)(1) STAFF TREATMENT OF CLIENTS			

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Bldg. 00	**The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.** Based on record review and interview for 3 of 3 sampled clients (clients A, B, and C) plus 3 additional clients (clients D, F, and G), the facility neglected to implement its policy and procedures to prevent multiple elopements involving client A, to ensure client A's protective measures were being followed, to ensure the immediate notification of supervisors/administration following a police visit, while conducting an investigation, to the group home while clients B, C, D, F, and G were sleeping, to ensure sufficient staff were present to prevent the elopement of client F, to ensure the completion of an investigation into the elopement of client F, and to ensure client F's BSP (Behavior Support Plan) was followed as written. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 2/21/20 at 10:41 AM. 1. A BDDS report dated 1/13/20 indicated, "...On 1/12/2020 while preparing lunch with staff and other housemates, [client A] told staff he wanted to use the bathroom. Staff checked on [client A] after 15 minutes, per his plan and discovered that he had eloped from the house, going out by opening the window in his room and removing the screen. Staff immediately informed supervisors and a search for [client A] commenced immediately. [Client A] was located at [name of hospital] Emergency Department...[Client A] was without ResCare staff supervision for approximately 55minutes (sic)...[Client A] is a new admission to the house and was (sic) 15-minute	W 0149	**CORRECTION:** *The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.* Specifically: Facility staff will be retrained regarding required reporting criteria and timelines. The governing body has hired an additional Quality Assurance Coordinator, who will be assigned to complete investigations at the facility. The addition of the new position will reduce the overall workload for each investigator by 20%, allowing for increased efficiency and attention to detail. 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	03/29/2020

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	checks per new admission protocol and does not have approved alone time...Additional protective measures put in place include line of sight observations during waking hours in addition to continuing 15-minutes checks while sleeping...". A review of the BDDS report dated 1/13/20 indicated client A eloped from the group home on 1/12/2020. The review indicated client A was without ResCare staff supervision for approximately 55 minutes. -An Investigative Summary (IS) dated 1/16/20 indicated the following: -"...Investigative Summary...". -"...Investigator(s) / Title(s) [QAC (Quality Assurance Coordinator) #1]...". -"...Introduction." -"On 1.12.20 at 11:55 AM [client A] (individual) while preparing lunch with [FMC (former medication coach) #1] and his housemates [client A] told [MC #1] he needed to use the bathroom. After 15-minutes [FMC #1] checked on [client A] and discovered that he had eloped from his bedroom window...[FMC #1] immediately notified the supervisor and the supervisor searched for [client A]. [Name of hospital] emergency room...personnel contacted [RM (Residential Manager) #1]...and reported [client A's] whereabouts...[Client A] was out of staff's sight for approximately 55 minutes...". -"...Scope of Investigation." -"1) Why did [client A] (individual) elope from the home for approximately 55 minutes?."		Manager, including but not limited to interview techniques, gathering and analysis of documentary evidence. The emphasis of this training will be development of appropriate scope and conclusions, including the need to expand the scope of investigations must be expanded when additional allegation(s) emerge. The QIDP Manager will provide weekly follow-up to the QA Manager regarding progress on current investigations. Client F no longer lives at the facility. All facility direct support and supervisory staff will be retrained on proper implementation of each client's Behavior Support Plan, including client A's enhanced supervision protocols. Additionally, when clients are visiting other ICF or Waiver homes, pending transition, the facility will provide training to direct support staff at the location of the visit to facilitate proper implementation of behavior supports. The Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than two staff on duty between 24/7, with additional staffing resources to be made available, based on acute need. Additionally, when clients are visiting other ICF or Waiver homes, pending transition, the facility will provide direct support	

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	-"2) Did staff follow ResCare Policy and Procedures appropriately?...". -"...Summary of Interviews...". -"...[Client A] (Individual)-." -"Why did you elope from the home?." -"Because she (FMC #1) made me upset." -"She told me not to elope again...". -"...[FMC #1]...". -"I was preparing lunch with the clients." -"[Client A] was making lunch too and he told me he had to use the bathroom." -"He's (client A) on 15-minute checks so after 15-minutes I checked on him and he was not in the bathroom." -"Had you (FMC #1) asked [client A] not to elope?." -"Yes, because he knew I was the only staff so I asked him not to elope." -"I checked his bedroom and when I opened the door the chest was in front of it." -"I moved the chest and saw that his bedroom window was open with the screen removed." -"I looked out of the window but did not see him." -"I went back to the other clients and call (sic)		staff at the location of the visit to assure required staffing ratios are in place. When direct support personnel are unavailable to provide coverage as described above, salaried supervisory staff will fill in, providing direct support as needed. **PREVENTION:** The Quality Assurance Manager and the QIDP Manager will carefully review all incidents reported by the facility and outside entities, to assure that allegations and other required incidents are reported to the Bureau of Developmental Disabilities Services as required by state law. Each day, QIDP Manager or designee will compile a list of incidents requiring reports to the Bureau of Developmental Disabilities Services, and distribute the list to administrative staff (including the Quality Assurance Manager, Program Managers, Quality Assurance Coordinators, Operations Manager, Area Supervisors, QIDP, Nurse Manager and Assistant Nurse Manager) for review and revision, as needed. The QIDP Manager or designee will assign reporting responsibilities daily. Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent via electronic fax directly to	

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	[RM #1]...". -"...I (FMC #1) couldn't leave the house because I was the only staff...". -"...[Staff #1]." -"I (staff #1) was in the living room and he said he was going to the bathroom." -"After 15-minutes she (FMC #1) checked on him and his door seemed locked." -"It was because he had pushed the dresser to the door so she pushed the door and found he had eloped from the window...". -"...[Client F]...". -"...We were making lunch and he (client A) said he had to use the bathroom." -"Staff (FMC #1) checked on him and then she said he had left the house." -"[FMC #1] looked for him but he was gone...". -"...[RM #1]...". -"...[FMC #1] called me and reported that [client A] had left the home." -"I (RM #1) asked what happened and she (FMC #1) stated that they were making lunch when [client A] said he had to use the bathroom." -"After 15-minutes she checked on him and found he had eloped from his bedroom window...". -"...I (RM #1) drove there and searched the area		administrative staff. The Quality Assurance Manager and the QIDP Manager will coordinate and follow-up with the Quality Assurance Coordinators, QIDPs and other staff responsible for reporting to outside agencies, to assure incidents are reported to state agencies as required. 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 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.	

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	then hospital staff called me around 1:45pm and said [client A] was there." -"I (RM #1) went to the hospital and picked him (client A) up at 1:50pm...". -"...Factual Findings...". -"...[FMC #1] last saw [client A] at 11:55am." -"15 minutes later at 12:10pm [FMC #1] checked on [client A], per his plan and discovered he had eloped." -"[RM #1] was notified that [client A] at (sic) the hospital around 1:45pm." -"[RM #1] went to the hospital at 1:50pm and she picked him up an hour later and transported him home." -"Additional protective measures put in place include line of sight observations during waking hours in addition to continuing 15-minutes checks while sleeping...". -"...Conclusion." -"1) It is substantiated that [client A] (individual) eloped from the home, approximately 55 minutes, because he was upset [FMC #1]...[Client A] told him not to elope again and that upset him so he left the home." -"2) It is unsubstantiated that staff followed ResCare Policy and Procedure appropriately...". A review of the IS dated 1/16/20 indicated client A eloped from the group home after asking staff to use the restroom. The review indicated client A		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 regulatory and operational standards. When incidents occur, The QIDP Manager will coordinate with the trained investigator and QIDP, through the investigation and corrective measure implementation process, to assure staff are trained to implement protective measures as written. Each evening for the next 90 days, the Residential Manager will submit a list of scheduled staff with their assigned hours, for the following day. The list will be reviewed by the Area Supervisor, Program Manager, Operations Manager, Quality Assurance Manager and QIDP Manager. Administrative staff will direct the team, making adjustments as needed. After 90 days, the Operations Manager and Quality Assurance Manager will determine	

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	eloped through his bedroom window. The review indicated client A was out of staff supervision for approximately 55 minutes. -A BDDS report dated 1/16/20 indicated, "...On 1/16/2020, during the 15 minutes check on [client A] by staff , he became verbally aggressive toward staff stating that he did not want to be checked on and that the heat in the house was high, (sic) staff turned the heat down and Staff (sic) checked on [client A] after 15 minutes, per his plan and discovered that he had eloped from the house, going out by opening the window in his room and removing the screen. Staff immediately informed supervisors and a search for [client A] commenced immediately. [Client A] was located at the [name of hospital] Emergency Department. ER (Emergency Room) personnel reported [client A] had contact EMS (Emergency Medical Services) from a gas station he had walked to from the house...[Client A] was without ResCare staff supervision for approximately 50 minutes...Additional protective measures put in place include line of sight observations during waking hours in addition and continuing 15-minutes checks while sleeping. Also, alarms have just been installed on the windows after obtaining HRC (Human Rights Committee) approval...". A review of the BDDS report dated 1/16/20 indicated client A eloped from the home on 1/15/20. The review indicated client A was without ResCare staff supervision for approximately 50 minutes. The review indicated alarms had just been been installed on the windows. -An IS dated 1/23/20 indicated the following: -"...Investigative Summary...".		the level of monitoring necessary to assure appropriate coverage. The Residential Manager will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor implementation of behavior supports as written. 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 daily administrative monitoring during varied shifts/times. After 30 days, administrative monitoring will occur no less than weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Administrative Monitoring is defined as follows: · 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	

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	-"...Investigator(s) / Title(s) [QAC #1]...". -"...Introduction." -"On 1.16.20 at 4:15AM staff checked on [client A] (individual) and he became verbally aggressive about staff completing 15-minute checks on him and that the heat was too high. Staff lowered the temperature for him. 4:30AM staff checked on [client A] and he (staff) could not locate him (client A) in his bedroom. [Staff #2] discovered that [client A's] bedroom window screen had been removed. [Staff #2] immediately searched the home for him. [Staff #2] notified [RM #1] and searched the neighborhood. [Staff #2] notified [RM #1] that [client A] could not be located in the neighborhood. [RM #1] had already notified the police. [RM #1] was notified by [client A's] mother that [client A] was at [name of hospital] emergency room...Emergency room personnel reported that [client A] had contacted EMS from a local gas station...[Client A] was out of staff's sight for approximately 50 minutes...". -"...Scope of Investigation." -"1) Why did [client A] (individual) elope from the home for approximately 50 minutes?" -"2) Did staff follow ResCare Policy and Procedures appropriately?...". -"...Summary of Interviews...". -"...[Client A] (individual) -." -"Why did you elope?." -"I was hot."		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 Administrative support at the home will include · Assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to assuring implementation of protective measures and Behavior Support Plans as written. · Assuring adequate direct support staff are on duty to meet the needs of all clients. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, BDDS Generalist, Regional Director	

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-"I took the screen out and moved the curtain over."

-"I put all my weight on the window and pushed out and popped the window to get through."

-"I jumped out the window...".

-"...[Staff #2]...".

-"He (client A) was in the bedroom sleeping."

-"I (staff #2) did the 15-minute checks on him and couldn't find him."

-"I saw his window was open and his screen was gone."

-"I called [RM #1] and did the incident report..".

-"...The hospital called the house and reported that he (client A) was at the hospital."

-"[RM #1] went to the hospital...".

-"...[Staff #3]."

-"[Staff #2] did the last check (15-minute check) and couldn't find him (client A)."

-"[Staff #2] checked around the house and couldn't find him...".

-"[RM #1] called back and told us he was at the hospital...".

-"...[RM #1]...".

-"Staff told me that they completed the 15-minute

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	checks on [client A] and at 4:15am he (client A) told [staff #2] that it was too hot." -"The staff lowered the temperature and when [staff #2] checked on him during the next 15-minute check he had eloped from his bedroom window already." -"Staff searched the home and outside the home for him...". -"...His (client A's) mother called me (RM #1) around 5:15am and told me he was at the hospital...". -"...I (RM #1) picked him (client A) up from the hospital around 5:20am...". -"...Factual Findings...". -"...[Staff #2] last saw [client A] at 4:15am." -"15 minutes later at 4:30am [staff #2] check on [client A], per his plan and discovered he had eloped...". -"...A window alarm has just been installed on [client A's] bedroom window, HRC (Human Rights Committee) approval was obtained for this...". -"...Conclusion." -"1) It is substantiated, by his (client A's) own admission, that [client A] (individual) eloped from, approximately 50 minutes, the home because the home was too hot...". A review of the IS dated 1/23/20 indicated client A eloped from the group home on 1/16/20. The review indicated client A eloped through his			

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	bedroom window. The review indicated client A was without ResCare supervision for approximately 50 minutes. -A BDDS report dated 1/19/20 indicated, "...On 1/18/20, [client A] had gone to sleep in his room and was receiving 15-minute checks per his plan. During a routine check, staff discovered [client A] was not in bed as noted during the last 15 minute check. Staff was unable to locate [client A] after immediately checking different areas inside the home and the outside perimeters of the home. It was discovered that [client A] climbed out of his bedroom window (turning off the window alarm). Staff immediately went to investigate and located [client A] at the [name of gas station]...Please note that [client A] was out of staff's line of sight for no more than 30 minutes. [Client A] will continue to receive line of sight observation during waking hours and 15-minute checks while sleeping...". A review of the BDDS report dated 1/19/20 indicated client A eloped from the home on 1/18/20. The review indicated client A eloped through his bedroom window and turned off the window alarm. The review indicated client A was out of staff's line of sight for 30 minutes. -An IS dated 1/23/20 indicated the following: -"...Investigative Summary...". -"...Investigator(s) / Title(s) [QAC #1]...". -"...Introduction." -"On 1.18.20 at 6:45PM [client A] (individual) [client A (sic)] was in his bedroom taking a nap then [staff #1] completed routine 15-minute checks on [client A] when he (staff #1) discovered			

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	[client A] was not in his bedroom. [Client A's] bedroom window was open and the window alarm was disabled. [Staff #1] immediately searched for him in the home and notified the supervisor. [Staff #1] searched the neighborhood and located [client A] at the [name of gas station]. [Client A] was out of staff's sight for approximately less than 30 minutes...". -"...Scope of Investigation." -"1) Why did [client A] (individual) elope from the home for approximately less than 30 minutes?" -"2) Did staff follow ResCare Policy and Procedures appropriately?...". -"...Summary of Interviews...". -"...[Client A]...". -"...Why did you (client A) elope from the home?" -"I (client A) just wanted to leave." -"I know how to take the alarm off the window and I put it under the mattress." -"I take the screen out and put it under my mattress...". -"...[Staff #1]...". -"...[Client A] was sleeping in his room." -"Staff (I (staff #1)) did my progress notes and then checked on him only to see that he was not present in his room." -"His (client A) bedroom window was open; it was			

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	around 6:45pm...". -"I found [client A] around 7:30pm at the [name] down the street...". -"...[Staff #4]...". -"...Immediately after dinner at 5:30pm, [client A] went to his room to take a nap; staff followed him and observed him lay down in his bed...". -"At 6:45pm when staff went back to check on him, for the 15-minute check, [client A] was not on his bed." -"Staff checked everywhere in the house and noticed the window in his room was open...". -"...Conclusion." -"1) It is substantiated by his (client A's) own admission, that [client A] (individual) eloped from the home from the home (sic) for approximately 30 minutes because he "wanted to." -"2) It is substantiated that staff followed ResCare Policy and Procedures appropriately...". A review of the IS dated 1/23/20 indicated client A eloped from the home on 1/18/20. The review indicated client A eloped through his bedroom window and disabled the window alarm. The review indicated client A was out of staff's sight for approximately 30 minutes. -A BDDS report dated 1/26/20 indicated, "...On 1/25/2020, while staff were attending to [client A's] housemates, [client A] eloped from the house and walked towards the railroad tracks while staff followed him offering support and redirection			

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	back to the house. The police were passing by and stopped to redirect [client A], but he became physically aggressive towards the police and he was placed in handcuffs and brought back to the house. Staff spoke with the police and he was released to staff back into the house. [Client A] continued to be verbally aggressive all evening, and became physically aggressive towards staff and punched staff in the face to run away from the house a second time. Staff informed supervisor and a search was initiated for [client A]. [Client A] returned to the house on his own...he was without ResCare supervision for approximately three hours...". A review of the BDDS report indicated client A eloped from the house and walked towards the railroad tracks while staff followed him offering support and redirection. The review indicated client A returned to the home. The review indicated after returning home, client A became verbally and physically aggressive towards staff and punched staff in the face. The review indicated client A then eloped from the house a second time. The review indicated client A returned home on his own from his second elopement. The review indicated client A was without ResCare supervision, during his second elopement, for approximately three hours. -An IS dated 1/31/20 indicated the following: -"...Investigative Summary...". -"...Investigator(s) / Title(s) [QAC #1]...". -"...Introduction." -"On 1.25.20 at 3:30 PM, while [staff #1] attended to [client A's] (individual) housemates [client A]			

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	eloped from the home. [Client A] walked to the railroad tracks. [Staff #1] followed and verbally redirected him back to the home, staff did not lose sight. [Staff #1] notified the supervisor. The police were patrolling and discovered the incident while in progress. The police stopped [client A]. [Client A] became physically aggressive toward the police. The police handcuffed [client A] and escorted him back to the home. Once home, [client A] continued to be verbally and physically aggressive toward [staff #2] for the remainder of the evening. At 6:45PM [client A] punched [staff #2] in the face and ran out the home. [Staff #2] followed [client A] and notified the supervisor. [Client A] returned to the home on his own. [Client A] eloped from the home for approximately 3 hours...". -"...Scope of Investigation." -"1) Why did [client A] (individual) elope from the home at 3:30 PM; never out of staff's sight?" -"2)Why did [client A] (individual) elope from the home at 6:45 PM for approximately 3 hours. (sic)?...". -"...4) Did staff follow ResCare Policy and Procedures appropriately?...". -"...Summary of Interviews...". -"...[Client A]...". -"...Why did you elope at 3:30pm?" -"[Staff #1] upset me." -"What did he do upset you?"			

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	-"I don't like people telling me what to do...". -"...Why did you elope at 6:45pm and punch [staff #2]?" -"Because he told me to sit down." -"Why did you elope after you punched him?" -"That just how I am." -"I left to calm down...". -"...[Staff #1]...". -"...What were you (staff #1) doing/which individuals were you assisting when [client A] eloped at 3:30pm?" -"I (staff #1) followed him and he was in line of sight...". -"...[Staff #2]...". -"...We were in the doorway of the office and he (client A) punched me (staff #2)." -"Then he eloped out the front door...". -"...Factual Findings." -"At 3:30pm [client A] walked out the home...Staff never lost sight of him." -"At 6:45pm [client A] eloped from the home and [staff #2] followed but lost sight of [client A]." -"[Client A] returned home on his own around 9:45pm...".			

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	-"...Conclusion." -"1) It is substantiated, by his (client A's) own admission, that [client A] (individual) eloped from the home at 3:30 PM (never our (sic) of staff's sight) because [staff #1] upset him because he gave him instructions and [client A] did not like when 'people tell him what to do.'" -"2) It is substantiated, by his (client A's) own admission, that [client A] (individual) eloped from the home at 6:45 PM for approximately 3 hours to calm down after [staff #2] told him to sit down...". -"...Recommendations...". -"...It is recommended that [client A] (individual) be placed on one-to-one staff supervision at all times...". A review of the IS dated 1/31/20 indicated client A eloped from the group home on 1/25/20 at 3:30 PM. The review indicated client A did not lose sight of him during the elopement. The review indicated client A eloped for a second time at 6:45 PM. The review indicated staff lost sight of client A during the second elopement. The review indicated client A returned home on his own. The review indicated client A was out of sight of ResCare staff for 3 hours. The review indicated a recommendation client A be placed on one-to-one staffing supervision all at times. -A BDDS report dated 2/6/20 indicated, "...On 2/5/2020, [client A] had gone to sleep and was receiving 15-minute checks per his plan. During a routine check, staff discovered [client A] was not in bed as noted during the last 15-minute check at 1:15am. Staff was unable to locate [client A] and checked different areas inside the home and the			

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	outside perimeters of the home. It was discovered that [client A] climbed out of his bedroom window (turning off the window alarm). Staff informed the supervisor immediately and a search for [client A] started. A missing person report was also filed with the police. [Client A] was found walking back on [name] street walking back to the house by staff...he was without ResCare supervision for approximately 7 hours...The interdisciplinary team has decided additional protective measures to include line of sight 24 hours of the day and the agency is researching an enhanced security system to be installed in the house...". A review of the BDDS report dated 2/6/20 indicated client A eloped on 2/5/20. The review indicated client A eloped through his bedroom window and disarmed the window alarm. The review indicated client A was without ResCare supervision for approximately 7 hours. The review indicated client A's interdisciplinary team decided to implement an additional protective measure to include line of sight 24 hours of the day. -An IS dated 2/10/20 indicated the following: -"...Investigative Summary...". -"...Investigator(s) / Title(s) [QAC #1]...". -"...Introduction." -"On 2.5.20 at 1:30AM [client A] (individual) had gone to sleep in his bedroom. [Staff #2] and [staff #5] completed 15-minute checks, per his (client A's) plan. [Staff #2] check (sic) on him at 1:15am. Around 1:20am [staff #2] heard [client A's] bedroom window alarm sounding. [Staff #5] ran to the bedroom and discovered that [client A] was not in his bed and observed his bedroom window			

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	open. [Staff #5] observed that the bedroom window alarm was disarmed. [Staff #2] and [staff #5] searched the home. [Staff #2] search (sic) the outside perimeters of the home and notified the (sic) [RM #1]. [RM #1] notified 911 and a police report was made. Around 8:30pm (sic) [RM #1] located [client A] walking on [name of street]; he was walking back to the home...[Client A] was out of staff's sight for approximately 7 hours...". -"...Scope of Investigation." -"1) Why did [client A] (individual) elope from the home for approximately 7 hours?" -"2) Did staff follow ResCare Policy and Procedures appropriately?...". -"...Summary of Interviews...". -"...[Client A]...". -"...Why did you elope?" -"Staff made me upset...". -"That's why I eloped. (because staff is telling me what to do)." -"I break the alarm off and put it under the mattress." -"I took the screen out of the window and put it under my mattress...". -"...[Staff #2]...". -"...[Client A] was asleep in his room at 1:15am." -"Therefore, I was in the med (medication) room			

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	faxing med audits and the other staff ([staff #5]) was in the kitchen doing cleaning." -"When I heard the alarm from [client A's] room the other staff ([staff #5]) immediately rushed to his room and discovered that [client A] had eloped from this (sic) window." -"We immediately started searching for him with (sic) and called [RM #1]...". -"...[Staff #5]...". -"...At around 1:15am staff checked on [client A] in his room but before 1:15am he was restless going and coming out." -"The other staff ([staff #2]) was faxing the med audits we completed while (sic) in the dining room deep cleaning." -"Around 1:20am we heard the alarm from [client A's] window." -"We ran to see what was going on." -"We realized [client A] had ran (sic) out of the window." -"[Staff #2] followed him and ran after him...". -"...[RM #1]...". -"...[Staff #2] was in the med room doing the med audit when [client A] eloped." -"The other staff (sic) doing deep cleaning in the kitchen." -"They heard the alarm and [staff #2] saw [client			

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	A] outside so he ran after him." -"[Client A] took the alarm off but not the sensor so they (staff) were able to hear the alarm." -"I (RM #1) found [client A] walking on [name of street] and he was walking back to the home." -"Factual Findings." -"[Staff #2] last saw [client A] at 1:15am." -"Around 1:20am [staff #2] heard [client A's] window alarm and [staff #5] discovered he had eloped...". -"Around 8:30pm (sic) [RM #1] located [client A] and redirected him to get in the van and transported him home." -"[Client A] was out of staff's sight for approximately 7 hours...". -"...Conclusion." -"1) It is substantiated that [client A] (individual) eloped from the home for approximately 7 hours because he was upset...". A review of the IS dated 2/10/20 indicated client A eloped from the home on 2/5/20. The review indicated client A eloped out of his bedroom window. The review indicated client A was without ResCare staff supervision for approximately 7 hours. -A BDDS report dated 2/17/20 indicated, "...On 2/16/2020, [client A] had just finished eating and told staff he needed to use the restroom, but staff discovered [client A] was missing. Staff was			

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	unable to locate [client A] and checked different areas inside the home and the outside perimeters of the home. It was discovered that [client A] climbed out of his bedroom window (turning off the window alarm). Staff informed the supervisor immediately and a search for [client A] started. A missing person report was also filed with the police. The police located [client A] a (sic) neighbor's house down the street and brought him back to the house...he (client A) was without ResCare supervision for approximately one hour and 15 minutes...The interdisciplinary team has decided additional protective measures to include 1:1 (one-to-one supervision) until further notice. A review of the BDDS report dated 2/17/20 indicated client A eloped on 2/16/20. The review indicated client A eloped through his bedroom window and disarmed the window alarm. The review indicated client A was without ResCare supervision for approximately one hour and 15 minutes. The review indicated client A's interdisciplinary team decided additional protective measures to include 1:1 supervision until further notice. -An IS dated 2/21/20 indicated the following: -"...Investigative Summary...". -"...Investigator(s) / Title(s) [QAC #1]...". -"...Introduction." -"On 2.16.20 at 6pm after [client A] (individual) finished his dinner he informed staff that he needed to use the bathroom. [Staff #6] was in the kitchen, [staff #1] was in the med room and [staff #2] was assisting individual. [Staff #2] discovered that [client A] eloped from his bedroom. Staff			

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	searched the area and notified the supervisor. The police were notified and a missing person's report was filed. The police located [client A] by a neighbor's house down the street and brought him back to the house...[Client A] was out of staff's sight for approximately 1 hour 15 minutes. Per his interdisciplinary Team (sic), [client A] has been placed on one-to-one enhanced supervision as a protective measure...". -"...1) Why did [client A] (Individual) (sic) for approximately 1 hour 15 minutes?" -"2) Did staff follow ResCare Policy and Procedures appropriately?...". -"...Summary of Interviews...". -"...[Client A]...". -"...Why did you elope?" -"Because staff hasn't been taking us anywhere...". -"...Where did you go when you eloped?" -"I went to a friend's house. They called 911 for me...". -"...[Staff #2]...". -"...[Client A] just finished his dinner while [staff #6] was in the kitchen cleaning up." -"[Staff #1] was in the med room passing medication." -"I (staff #2) was changing [client B's] [incontinence brief]."			

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-"[Client A] went to his room and disarmed his window and eloped out of his window."

-"How did you know he (client A) was gone?"

-"I (staff #2) did a 15-minute check on him and noticed he was gone."

-"I (staff #2) went into the room and saw is (sic) window was open, I looked out the window and discovered him running down the street."

-"[Staff #2] and [staff #1] immediately went out to search for [client A]."

-"[RM #1] came to the site to assist with the search for [client A]."

-"[Client A] was found by the police...".

-"...[Staff #6]...".

-"...[Client A] finished having dinner."

-"[Staff #1] was passing medication."

-"[Staff #6] was in the kitchen cleaning up."

-"[Staff #2] was changing [client B's] [incontinence brief]."

-"[Client A] went to his room and disarmed the window and eloped out of the window."

-"[Staff #2] and [staff #1] went out in search of [client A]...".

-"...[Staff #1]...".

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	-"...[Client A] finished having dinner." -"[Staff #1] was passing medication." -"[Staff #6] was in the kitchen cleaning up." -"[Staff #2] was changing [client B's] [incontinence brief]." -"[Client A] went to his room and disarmed the window and eloped out of the window...". -"...[RM #1]...". -"...Staff called around 6pm and stated [client A] disarmed the window alarm and eloped out of the bedroom window." -"[Staff #1] was in the med room passing med's." -"[Staff #6] was preparing dinner." -"[Staff #2] was changing another consumer ([client B])." -"Police were called however no formal report was filed due to hi (sic) being located." -"[Client A] was at the home down the street...". -"...Factual Findings...". -"...Approximately 6:15pm [staff #2] discovered [client A] had eloped from his bedroom window." -"Staff searched for him." -"...Approximately 7:30pm, 1 hour 15 minutes later, the police located [client A] walking down the street of the home. He was one home away from			

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	[name of group home]...". -"...Conclusion." -"1) It is substantiated that [client A] (individual) (sic) for approximately 1 hour 15 minutes...". -"...2) It is unsubstantiated that staff followed ResCare Policy and Procedures appropriately...". A review of the IS dated 2/21/20 indicated client A eloped on 2/16/20. The review indicated client A eloped out of his bedroom window and disarmed his window alarm in his bedroom. The review indicated staff #1 was passing medication. The review indicated staff #2 was changing client B. The review indicated staff #6 was in the kitchen. The review did not indicate client A was in line of sight of staff during waking hours when he (client A) eloped. Client A's record was reviewed on 2/24/20 at 12:35 PM. -Client A's BSP (Behavioral Support Plan) dated 1/1/2020 indicated the following: -"...Behavioral Support Plan...". -"...Individual: [client A]." -"Date: 1.1.2020...". -"...Since moving into his present living residence on the 10th January, 2020 [client A] has eloped four different times...[Client A] returned to the home with enhanced security system to warn of elopement actions and it included alarms on all exit doors and the windows in [client A's] room...".			

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	-"...Rights Restrictions: The team has reviewed the risks for each of the below stated rights restrictions and agrees that the restrictions should be implemented as stated to ensure health and safety for all person in the environment." -"Restrictions...". -"...Line of Sight...". -"...Risks to Individual...". -"...[Client A] will walk or run away from staff members or he will engage in physical aggression when he is around his housemates...". -"...Plan to Restore Rights...". -"...Staff needs to make sure that they can see the consumer at all times due to her (sic) target behaviors. He (client A) can and will harm other individuals in the home if not supervised, as well as leaving the home...". -"...[client A], BSP Addendum, 2/5/2020:." -"Enhanced Supervision:." -"Due to a recent pattern of elopement and property destruction that has led to psychiatric hospitalization and incarceration, [client A] will receive 24hours (sic) line of sight. This supervision is defined as within line of sight at all times. When [client A] is in his room, staff will position themselves outside of the door with the door cracked so that line of sight is maintained." -"If [client A] moves around, the staff is expected to move with him. It is unacceptable for [male name] (sic) to be in one room, and his assigned			

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	staff to be in another. As stated above, when [client A] is in his room staff may be in the hallway, with his door slightly open, in order to maintain line of sight. Privacy may be maintained in the bathroom, with the door shut, but the assigned staff must remain outside the bathroom door...". -"...For no reason is the (sic) [client A] to be out of staff line of sight...".A review of client A's BSP dated 1/1/20 indicated client A had enhanced security implemented to warn of his elopement actions due to four elopements since his admission to the group home on 1/10/20. The review indicated the enhanced security included alarms on all exit doors and the windows in client A's room. The review indicated client A had a rights restriction for line of sight. The review indicated the line of sight restriction was implemented due to the risk of client A walking or running away from staff members or engaging in physical aggression. The review indicated the plan implemented to ensure line of sight was for staff to make sure they can see client A at all times. The review indicated an addendum to the BSP dated 2/5/20 which implemented enhanced supervision for client A due to recent pattern of elopement and property destruction. The review indicated the addendum included an implementation of 24 hour line of sight supervision for client A. The review indicated the 24 hour line of sight supervision			

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	was defined as within line of sight at all times. The review indicated client A was for no reason to be out of staff line of sight. -A 15 minute check tracking sheet for client A dated 1/12/2020 indicated no documentation by staff of the 15 minute tracking being completed between 8:15 AM through 3:45 PM. The review did not indicate documentation of the 15 minute checks being completed as was indicated by staff to have been occurring during the time of the elopement incident involving client A on 1/12/20.-A 15 minute check tracking sheet for client A dated 1/18/20 indicated staff #4 documented a completion of 15 minute checks for client A between 3:30 PM through 9:45 PM. The review indicated staff #4 documented, on the 15 minute check tracking sheet, client A was awake and in the living from from 6:45 PM through 7:30 PM. The review indicated documentation by staff #4 of client A's location to be awake and in the living room from 6:45 PM through 7:30 PM, compared to the Investigative Summary dated 1/23/20 which indicated client A had eloped from the home at 6:45 PM and was located outside the home at 7:30 PM by staff #1 on 1/18/20.-A 15 minute check tracking sheet for client A dated 1/25/20 indicated no documentation by staff of the 15 minute check being completed between 3:30 PM through 7:45			

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	PM. The review indicated staff #2 documented, on the 15 minute check tracking sheet, client A was awake and in the living room from 8:00 PM through 11:45 PM. The review indicated documentation by staff #2 of client A's location to be awake and in the living room from 8:00 PM through 9:30 PM, compared to the Investigative Summary dated 1/31/20 which indicated client A had eloped from the home at 6:30 PM and did not return to the home until 9:30 PM on 1/25/20.-A 15 minute check tracking sheet for client A dated 2/5/20 indicated staff #2 documented a completion of 15 minute checks for client A between 12:00 AM through 8:00 AM. The review indicated staff #2 documented client A was awake and in his bedroom from 12:00 AM through 6:30 AM. The review indicated staff #2 documented client A was awake and in the living room from 6:45 AM through 8:00 AM. The review indicated documentation by staff #2 of client A's location to be awake and in his bedroom from 1:15 AM through 6:30 AM and awake and in the living room from 6:45 AM through 8:00 AM, compared to an Investigative Summary dated 2/10/20 which indicated client A had eloped out of the group home at 1:20 AM and did not return to the group home until 8:30 AM. QIDPM (Qualified Intellectual Disabilities Professional Manager) #1 was interviewed			

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	on 2/24/20 at 1:55 PM. QIDPM #1 was asked about client A's initial admission into the group home. QIDPM #1 indicated client A was admitted to the group home on 1/10/2020. QIDPM #1 was asked about client A's supervision level at the time of admission. QIDPM #1 indicated client A was on 15 minute checks, twenty four hours of the day, seven days a week, per protocol for new admissions. QIDPM #1 was asked about client A's multiple elopements in January 2020 and February 2020 and the protective measures being put in place. QIDPM #1 indicated they have gone from 15 minute checks throughout the day, to line of sight during waking hours with 15 minute checks during sleeping hours, to 24 hour enhanced supervision, to 1:1 supervision. QIDPM #1 also indicated alarms had been installed on client A's window. QIDPM #1 was asked about client A's supervision level at the time of his elopement on 2/16/20. QIDPM #1 stated, "He was still on 24 hour supervision." QIDPM #1 was asked about the number of staff working at the time of client A's elopement on 2/16/20. QIDPM #1 stated, "Three." QIDPM #1 was asked if client A's supervision level requirements were being followed at the time of the elopement on 2/16/20. QIDPM #1 stated, "No." QIDPM #1 was interviewed a second time on 2/25/20 at 2:58 PM. QIDPM #1			

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	was asked about the date in which the facility implemented 1:1 supervision for client A. QIDPM #1 stated, "I double checked. It was implemented on the afternoon of 2/5/2020." QIDPM #1 was asked if the investigation completed on 1/31/20 into the elopement of client A on 1/25/20 indicated a recommendation for client A to be placed on one-to-one supervision. QIDPM #1 stated, "Yes." QIDPM #1 was asked why the one-to-one supervision was not implemented following the recommendation on 1/31/20. QIDPM #1 indicated the investigator had not collaborated with the QIDP (Qualified Intellectual Disability Professional) after the investigation was completed, which is now part of their process. 2. A BDDS report dated 1/31/20 indicated, "...On the evening of 1/30/20, the Executive Director received a phone call from a neighbor who reported that on 1/29/20, at approximately 11:30 PM, off duty ResCare staff [FS (Former Staff) #1] engaged in a verbal altercation with a neighbor while waiting to pick up on-duty ResCare staff [FMC #1]. The caller reported that as he (FS #1) was pulling away, staff [FS #1] discharged a firearm from his open car window. The caller said a police report was filed. The ResCare Program Manager spoke to the [name] Police, who confirmed they were			

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	investigating a report of shots fired in the neighborhood...".A review of the BDDS report dated 1/31/20 indicated a verbal altercation occurred outside of the group home involving FS #1 and a neighbor of the group home. The review indicated FS #1 was not working at the group home at the time but was there to pick up FMC #1 who was finishing her shift. The review indicated as FS #1 was driving away, he discharged a firearm from his open car window. This affected clients B, C, D, F and G.-An IS dated 2/6/20 indicated the following: -"...Investigative Summary...". -"...Investigator(s) / Title(s) [HRS (Human Resource Specialist) #1]...". -"...Introduction."-"On 1/30/20 it was reported that gunshots were fired outside the [name] group home around 11:15pm the night before. A neighbor stated that they saw a female come out of the [name] ICF (Intermediate Care Facility) home and jump into a car. As the car pulled off 2 gunshots were heard. Female was identified as DSP (Direct Support Professional) [FMC #1]. [FMC #1] has a personal relationship with DSP [FS #1]...".-"...Scope of Investigation...".-"...5. Did any individuals who live at [name of group home] see or hear the alleged incident?...".-"...Summary of Interviews...".-"...[GHN (Group Home Neighbor) #1]...".-"...Around 11:15pm my			

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	husband and I heard someone laying on the horn..."."-"...We (GHN #1 and husband) went outside to see."-"We saw a young male in a dark [brand of car] laying on the horn."-"My husband (GHN #1's) went out and tapped on the window."-"The young man threatened...my husband..."."-"...The man (identified FS #1) said he had something for my husband and went to reach back in the car."-"I (GHN #1) called for my husband to come back to the house."-"A young woman (identified as FMC #1) came out of the house (group home) and jumped in the car."-"My husband and I walked up the side walk to our house and 2 gunshots rung out as the car drove off."-"I (GHN #1) called the police..."."-"...[PD (Police Detective] #1]..."."-"We (police) got a call around 11:15pm on Wednesday night."-"We went to your [name] group home."-"And found bullet (sic) 3 bullet casings."-"The Neighbors told (sic) a man was blaring his car horn and when they came out to investigate the husband had a verbal altercation with the male in the car."-"A woman came out of your group home (ResCare's group home) and got in the car with the man."-"When they (identified as FS #1 and FMC #1) drove off 3 shots were fired..."."-"...There was evidence that the shots hit near the reporting neighbor's walkway that leads to the front door (of the			

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	neighbors house.)...".-"...We (police) went to the [name] group home and met with the staff on duty, [staff #3]."-"[Staff #3] stated to us that the only person to leave was a staffed named [FMC #1]."-"The staff (staff #3) stated that [FMC #1's] ride had come to pick her up and she left."-"[Staff #3]...". -"...[FMC #1] left the site around 11:30pm on 1/30/20...".-"...I heard 2 loud bangs shortly after [FMC #1] left."-"I (staff #3) assumed they were gun shots."-"I (staff #3) locked the door."-"I did not go outside."-"I (staff #3) did not immediately report the incident...".-"...Factual Findings."-"1. [FMC #1] worked from 4:23p-11:38pm on 1/29/2020...".-"...2. [FMC #1] got in a dark [brand of car] driven by [identifying characteristics]."-"3. [FMC #1] has informed...that [FS #1] is her boyfriend...". -"...6. 2 gunshots were heard around the time [FMC #1] left [name] group home by 2 neighbors and staff [staff #3]...".A review of the IS dated 2/6/2020 indicated a verbal altercation occurred between FS #1 and a neighbor outside of the group home on the evening of 1/29/20. The review indicated FS #1 was not working at the group home but was picking up FMC #1 at the end of her shift at the group home. The review indicated during the verbal altercation between FS #1 and the neighbor, FMC #1 came out of the group home and got in FS			

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	#1's car. The review indicated as FS #1 and FMC #1 drove off a firearm was displayed out of the window of FS #1's car and gun shots occurred. The review indicated staff #3 heard two bangs outside of the group home shortly after FMC #1 left. The review indicated staff #3 assumed the bangs were gun shots, did not go outside, and locked the doors. The review indicated PD #1 stated she went to the group home and met with the staff on duty (indicated as staff #3). The review indicated staff #3 did not immediately report the incident to the supervisor or administration.AS (Area Supervisor) #1 was interviewed on 2/21/20 at 11:58 AM. AS #1 was asked when he was notified of an incident involving an argument occurring outside of the group home and gun shots outside of the group home. AS #1 stated, "The next morning, the morning of the 30th (1/30/20). The other staff who was working didn't go outside. He (staff working) didn't know anything had occurred until the police had come asking questions and filling them in about incident."QAM (Quality Assurance Manager) #1 was interviewed on 2/21/20 at 11:51 AM. QAM #1 was asked when were administration notified of the incident involving an argument occurring outside of the group home and gun shots outside of the group home. QAM #1 stated, "At 9:54 AM on the 30th (1/30/20) I received an email			

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	from [AS #1]."HRS (Human Resource Specialist) #1 was interviewed on 2/24/20 at 1:55 PM. HRS #1 was asked if PD #1 indicated they visited the group home during their investigation and when. HRS #1 stated, "Twice that night."QIDPM #1 was interviewed on 2/24/20 at 1:55 PM. QIDPM #1 was asked when were the supervisors/administration notified of the incident involving gun shots outside of the group home which involved two ResCare employees. QIDPM #1 stated, "Around 9:54 AM, but no identification at that time of Rescare staff involvement." QIDPM #1 was asked if any of the staff or clients in the home aware of the incident taking place or hearing gun shots. QIDPM #1 stated, "No. QIDPM #1 was asked if an investigation into the incident on 1/29/20 dated 2/6/20 indicated staff #3 heard 2 loud bangs shortly after FMC #1 left and assumed they were gun shots. QIDPM #1 stated, "Yes." QIDPM #1 was asked if the facility had an expectation of staff to notify supervisor or administration of any safety concerns/environmental concerns of which occur around or in the group home. QIDPM #1 stated, "Yes." QIDPM #1 was asked if a staff were to hear gun shots occurring outside of the group home, would the facility expect the staff to notify the supervisor or administration. QIDPM #1 stated, "Yes."			

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	QIDPM #1 was asked if the [staff #3] notified the supervisor or administration of hearing gun shots outside the group home on the evening of 1/29/20. QIDPM #1 stated, "No." QIDPM #1 was asked if PD #1, in her statements, during her interview with the investigator indicate the police visited the group home. QIDPM #1 stated, "Yes." QIDPM #1 was asked if the facility has an expectation of staff to notify the supervisor or administration immediately if the police were to visit the group home. QIDPM #1 stated, "Yes, if the police come to the home, the administration needs to be notified." QIDPM #1 was asked if staff #3 notified the supervisor or administration of the police visit immediately. QIDPM #1 stated, "No."3. A BDDS report dated 2/12/20 indicated, "...On the night of 12/11/20 (sic), while visiting a ResCare waiver home...staff observed [client F] hiding a valve from an air mattress in her hand. Staff observed that she (client F) had used the valve to scratch her right wrist. Staff redirected [client F] verbally and she provided the object to staff...Staff observed a variety of activities and she began watching television with staff and remained calm for 1.5 hours. At 12:15 AM, [client F] stood up and began pacing, (sic) Staff provided verbal redirection and [client F] began to escalate. She (client F) exited the house and staff lost line of sight, due to			

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	not being able to leave because other individuals were asleep in the home...It should be noted that [client F] does not have plan approved alone time...".A review of the BDDS report dated 2/12/20 indicated client F, while visiting a ResCare waiver home, obtained a valve from an air mattress and used the valve to scratch her right wrist. The review indicated client F provided the valve to staff after verbal redirection. The review indicated client F eloped from the group home. The review indicated only one staff was on duty during the elopement incident. The review did not indicate a completed investigation into the elopement of client F on 2/11/20. Client F's record review was on 2/24/20 at 10:22 AM. -Client F's BSP (Behavioral Support Plan) dated November 2019 indicated the following:-"...Consumer: [client F]...".-"...Plan Date: November 2019...".-"...History...".-"...She (client F) will make any number of items she may find in the home a weapon and attempt to try to cut herself...".-"...Target Behaviors & Goals...". -"...Elopement: Any instance in which she leaves the area that she is supposed to be present, takes it upon herself to leave without telling staff members where she is going...".-"...Self-Injurious Behavior: This includes but is not limited to head banging, cutting, hair pulling, putting self in dangerous situations, or any attempt to harm self...".			

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	-"...Rights Restrictions: The team has reviewed the risks for each of the below stated rights restrictions and agrees that the restrictions should be implemented as stated to ensure health and safety for all person in the environment...".-"...Restrictions...". -"...Sharps (Knives forks, scissors, etc.)...". -"...Line of Sight...".-"...Risks to Individual...".-"...[Client F] will engage in self harm and extreme physical aggression towards staff when these items are present...".-"...[Client F] will walk or run away from staff members or she will engage in physical aggression when she is around her housemates...".-"...Plan to Restore Rights...".-"...All of these items should be removed from the home or placed in a locked area where [client F] does not have access...".-"...Staff needs to make sure they can see the consumer at all times due to her target behaviors...".A review of client F's BSP dated November 2019 indicated client F had a history of making any number of items she may find in the home a weapon and attempted to try to cut herself. The review indicated client F had target behaviors and goals for elopement and self-injurious behavior. The review indicated client F had a right restriction for sharps and a right restriction for line of sight. QIDPM #1 was interviewed on 2/24/20 at 1:55 PM. QIDPM #1 was asked if client F, while			

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	visiting a ResCare Waiver home on 2/11/20, obtained a valve from air mattress and utilized it to scratch herself. QIDPM #1 stated, "Yes." QIDPM #1 was asked if client F had a sharps restriction implemented in her BSP. QIDPM #1 stated, "Yes." QIDPM #1 was asked if client F should have been able to obtain a valve to scratch herself. QIDPM #1 stated, "No." QIDPM #1 was asked if all staff at the ResCare waiver home were trained regarding client F's BSP/risk plans prior to the overnight visit on 2/11/20. QIDPM #1 stated, "Yes." QIDPM #1 was about client F's level of supervision. QIDPM #1 indicated client F was line of sight during waking hours and 15 minute checks while sleeping. QIDPM #1 was asked if client F eloped from the ResCare Waiver home on 2/11/20. QIDPM #1 stated, "Yes." QIDPM #1 was asked about the number of staff working when client F eloped from the home on 2/11/20. QIDPM #1 stated, "One." QIDPM #1 was asked if more than one staff should have been present at the time of client F's elopement. QIDPM #1 stated, "To meet the staffing requirements there should have been two staff." QIDPM #1 was asked if only one staff working at the group home with multiple clients can meet the requirements needed to provide client F's supervision level and prevent elopements of client F. QIDPM			

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	#1 stated, "No."The Facility's policy and procedures were reviewed on 2/25/20 at 9:52 AM. The facility's Abuse, Neglect, Exploitation policy revised on 2/26/18 indicated, "Policy: Adept staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect and exploitation shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of ADEPT, ResCare and local, state and federal guidelines..."Emotional/physical neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide the support necessary to an individual's psychological and social well being. Failure to meet the basic need requirements such as food, shelter, clothing and to provide a safe environment." "Program intervention neglect: ...Failure to implement a support plan, inappropriate application of intervention with out (sic) a qualified person notification/review..."."6. A full investigation will be conducted by ADEPT personnel...".This federal tag relates to complaint #IN00318381.9-3-2(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			

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	immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 9 allegations of abuse, neglect, and mistreatment reviewed, the facility failed to ensure staff reported an incident involving police visiting the group home overnight during an investigation, while clients B, C, D, F, and G were sleeping, immediately to the supervisor or administration. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 2/21/20 at 10:41 AM. A BDDS report dated 1/31/20 indicated, "...On the evening of 1/30/20, the Executive Director received a phone call from a neighbor who reported that on 1/29/20, at approximately 11:30 PM, off duty ResCare staff [FS (Former Staff) #1] engaged in a verbal altercation with a neighbor while waiting to pick up on-duty ResCare staff [FMC #1]. The caller reported that as he (FS #1) was pulling away, staff [FS #1] discharged a firearm from his open car window. The caller said a police report was filed. The ResCare Program Manager spoke to the [name] Police, who confirmed they were investigating a report of shots fired in the neighborhood...". A review of the BDDS report dated 1/31/20 indicated a verbal altercation occurred outside of the group home involving FS #1 and a neighbor of the group home. The review indicated FS #1 was not working at the group home at the time but was there to pick up FMC #1 who was finishing her shift. The review indicated as FS #1 was driving away, he discharged a firearm from his open car	W 0153	**CORRECTION:** *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.* Specifically, facility staff will be retrained regarding required reporting criteria and timelines. **PREVENTION:** The Quality Assurance Manager and the QIDP Manager will carefully review all incidents reported by the facility and outside entities, to assure that allegations and other required incidents are reported to the Bureau of Developmental Disabilities Services as required by state law. Each day, QIDP Manager or designee will compile a list of incidents requiring reports to the Bureau of Developmental Disabilities Services, and distribute the list to administrative staff (including the Quality Assurance Manager, Program Managers, Quality Assurance Coordinators, Operations Manager, Area Supervisors, QIDP, Nurse Manager and Assistant Nurse Manager) for review and revision, as needed. The QIDP Manager or designee will assign	03/29/2020

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	window. This affected clients B, C, D, F and G. -An IS dated 2/6/20 indicated the following: -"...Investigative Summary...". -"...Investigator(s) / Title(s) [HRS (Human Resource Specialist) #1]...". -"...Introduction." -"On 1/30/20 it was reported that gunshots were fired outside the [name] group home around 11:15pm the night before. A neighbor stated that they saw a female come out of the [name] ICF (Intermediate Care Facility) home and jump into a car. As the car pulled off 2 gunshots were heard. Female was identified as DSP (Direct Support Professional) [FMC #1]. [FMC #1] has a personal relationship with DSP [FS #1]...". -"...Scope of Investigation...". -"...5. Did any individuals who live at [name of group home] see or hear the alleged incident?...". -"...Summary of Interviews...". -"...[GHN (Group Home Neighbor) #1]...". -"...Around 11:15pm my husband and I heard someone laying on the horn...". -"...We (GHN #1 and husband) went outside to see." -"We saw a young male in a dark [brand of car] laying on the horn." -"My husband (GHN #1's) went out and tapped		reporting responsibilities daily. Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent via electronic fax directly to administrative staff. The Quality Assurance Manager and the QIDP Manager will coordinate and follow-up with the Quality Assurance Coordinators, QIDPs and other staff responsible for reporting to outside agencies, to assure incidents are reported to state agencies as required. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	

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	on the window." -"The young man threatened...my husband...". -"...The man (identified FS #1) said he had something for my husband and went to reach back in the car." -"I (GHN #1) called for my husband to come back to the house." -"A young woman (identified as FMC #1) came out of the house (group home) and jumped in the car." -"My husband and I walked up the side walk to our house and 2 gunshots rung out as the car drove off." -"I (GHN #1) called the police...". -"...[PD (Police Detective] #1]...". -"We (police) got a call around 11:15pm on Wednesday night." -"We went to your [name] group home." -"And found bullet (sic) 3 bullet casings." -"The Neighbors told (sic) a man was blaring his car horn and when they came out to investigate the husband had a verbal altercation with the male in the car." -"A woman came out of your group home (ResCare's group home) and got in the car with the man." -"When they (identified as FS #1 and FMC #1)			

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	drove off 3 shots were fired...". -"...There was evidence that the shots hit near the reporting neighbor's walkway that leads to the front door (of the neighbors house.)...". -"...We (police) went to the [name] group home and met with the staff on duty, [staff #3]." -"[Staff #3] stated to us that the only person to leave was a staffed named [FMC #1]." -"The staff (staff #3) stated that [FMC #1's] ride had come to pick her up and she left." -"[Staff #3]...". -"...[FMC #1] left the site around 11:30pm on 1/30/20...". -"...I heard 2 loud bangs shortly after [FMC #1] left." -"I (staff #3) assumed they were gun shots." -"I (staff #3) locked the door." -"I did not go outside." -"I (staff #3) did not immediately report the incident...". -"...Factual Findings." -"1. [FMC #1] worked from 4:23p-11:38pm on 1/29/2020...". -"...2. [FMC #1] got in a dark [brand of car] driven by [identifying characteristics]."			

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	-"3. [FMC #1] has informed...that [FS #1] is her boyfriend...". -"...6. 2 gunshots were heard around the time [FMC #1] left [name] group home by 2 neighbors and staff [staff #3]...". A review of the IS dated 2/6/2020 indicated a verbal altercation occurred between FS #1 and a neighbor outside of the group home on the evening of 1/29/20. The review indicated FS #1 was not working at the group home but was picking up FMC #1 at the end of her shift at the group home. The review indicated during the verbal altercation between FS #1 and the neighbor, FMC #1 came out of the group home and got in FS #1's car. The review indicated as FS #1 and FMC #1 drove off a firearm was displayed out of the window of FS #1's car and gun shots occurred. The review indicated staff #3 heard two bangs outside of the group home shortly after FMC #1 left. The review indicated staff #3 assumed the bangs were gun shots, did not go outside, and locked the doors. The review indicated PD #1 stated she went to the group home and met with the staff on duty (indicated as staff #3). The review indicated staff #3 did not immediately report the incident to the supervisor or administration. AS (Area Supervisor) #1 was interviewed on 2/21/20 at 11:58 AM. AS #1 was asked when he was notified of an incident involving an argument occurring outside of the group home and gun shots outside of the group home. AS #1 stated, "The next morning, the morning of the 30th (1/30/20). The other staff who was working didn't go outside. He (staff working) didn't know anything had occurred until the police had come asking questions and filling them in about			

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	15G465	A. BUILDING 00 B. WING	02/28/2020

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	incident." QAM (Quality Assurance Manager) #1 was interviewed on 2/21/20 at 11:51 AM. QAM #1 was asked when were administration notified of the incident involving an argument occurring outside of the group home and gun shots outside of the group home. QAM #1 stated, "At 9:54 AM on the 30th (1/30/20) I received an email from [AS #1]." HRS (Human Resource Specialist) #1 was interviewed on 2/24/20 at 1:55 PM. HRS #1 was asked if PD #1 indicated they visited the group home during their investigation and when. HRS #1 stated, "Twice that night." QIDPM (Qualified Intellectual Disabilities Professional Manager) #1 was interviewed on 2/24/20 at 1:55 PM. QIDPM #1 was asked when were the supervisors/administration notified of the incident involving gun shots outside of the group home which involved two ResCare employees. QIDPM #1 stated, "Around 9:54 AM, but no identification at that time of Rescare staff involvement." QIDPM #1 was asked if any of the staff or clients in the home aware of the incident taking place or hearing gun shots. QIDPM #1 stated, "No. QIDPM #1 was asked if the facility had an expectation of staff to notify supervisor or administration of any safety concerns/environmental concerns of which occur around or in the group home. QIDPM #1 stated, "Yes." QIDPM #1 was asked if a staff were to hear gun shots occurring outside of the group home, would the facility expect the staff to notify the supervisor or administration. QIDPM #1 stated, "Yes." QIDPM #1 was asked if the [staff #3] notified the supervisor or administration of hearing gun shots outside the group home on the evening of 1/29/20. QIDPM #1 stated, "No."			

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	QIDPM #1 was asked if PD #1, in her statements, during her interview with the investigator indicate the police visited the group home. QIDPM #1 stated, "Yes." QIDPM #1 was asked if the facility has an expectation of staff to notify the supervisor or administration immediately if the police were to visit the group home. QIDPM #1 stated, "Yes, if the police come to the home, the administration needs to be notified." QIDPM #1 was asked if staff #3 notified the supervisor or administration of the police visit immediately. QIDPM #1 stated, "No." 9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 3 of 9 allegations of abuse, neglect, and mistreatment reviewed, the facility failed to complete a thorough investigation into two elopements of client A, and failed to complete an investigation into the elopement of client F. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 2/21/20 at 10:41 AM. 1. A BDDS report dated 1/13/20 indicated, "...On 1/12/2020 while preparing lunch with staff and other housemates, [client A] told staff he wanted to use the bathroom. Staff checked on [client A] after 15 minutes, per his plan and discovered that he had eloped from the house, going out by opening the window in his room and removing the screen. Staff immediately informed supervisors	W 0154	**CORRECTION:** *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: The governing body has hired an additional Quality Assurance Coordinator, who will be assigned to complete investigations at the facility. The addition of the new position will reduce the overall workload for each investigator by 20%, allowing for increased efficiency and attention to detail. All facility investigations will be completed by trained	03/29/2020

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	and a search for [client A] commenced immediately. [Client A] was located at [name of hospital] Emergency Department...[Client A] was without ResCare staff supervision for approximately 55minutes (sic)...". A review of the BDDS report dated 1/13/20 indicated client A eloped from the home on 1/12/20. The review indicated client a eloped through his bedroom window. The review indicated client A was without ResCare staff supervision for approximately 55 minutes. -An Investigative Summary (IS) dated 1/16/20 indicated the following: -"...Investigative Summary...". -"...Investigator(s) / Title(s) [QAC (Quality Assurance Coordinator) #1]...". -"...Introduction." -"On 1.12.20 at 11:55AM [client A] (individual) while preparing lunch with [MC (medication coach) #1] and his housemates [client A] told [MC #1] he needed to use the bathroom. After 15-minutes [MC #1] checked on [client A] and discovered that he had eloped from his bedroom window...[MC #1] immediately notified the supervisor and the supervisor searched for [client A]. [Name of hospital] emergency room...personnel contacted [RM (Residential Manager) #1]...and reported [client A's] whereabouts...[Client A] was out of staff's sight for approximately 55 minutes...". -"...Scope of Investigation." -"1) Why did [client A] (individual) elope from the		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, including but not limited to interview techniques, gathering and analysis of documentary evidence. The emphasis of this training will be development of appropriate scope and conclusions, including the need to expand the scope of investigations must be expanded when additional allegation(s) emerge. The QIDP Manager will provide weekly follow-up to the QA Manager regarding progress on current investigations. **PREVENTION:** 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,	

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	home for approximately 55 minutes?." -"2) Did staff follow ResCare Policy and Procedures appropriately?...". -"...Summary of Interviews...". -"...[Client A] (Individual)-." -"Why did you elope from the home?." -"Because she (MC #1) made me upset." -"She told me not to elope again...". -"...[MC #1]...". -"I was preparing lunch with the clients." -"[Client A] was making lunch too and he told me he had to use the bathroom." -"He's (client A) on 15-minute checks so after 15-minutes I checked on him and he was not in the bathroom." -"Had you (MC #1) asked [client A] not to elope?." -"Yes, because he knew I was the only staff so I asked him not to elope." -"I checked his bedroom and when I opened the door the chest was in front of it." -"I moved the chest and saw that his bedroom window was open with the screen removed." -"I looked out of the window but did not see him."		Program 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 regulatory	

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	-"I went back to the other clients and call (sic) [RM #1]...". -"...I (MC #1) couldn't leave the house because I was the only staff...". -"...[Staff #1]." -"I (staff #1) was in the living room and he said he was going to the bathroom." -"After 15-minutes she (MC #1) checked on him and his door seemed locked." -"It was because he had pushed the dresser to the door so she pushed the door and found he had eloped from the window." -"I (staff #1) was helping with lunch...". -"...[Client F]...". -"...We were making lunch and he (client A) said he had to use the bathroom." -"Staff (MC #1) checked on him and then she said he had left the house." -"[MC #1] looked for him but he was gone...". -"...[RM #1]...". -"...[MC #1] called me and reported that [client A] had left the home." -"I (RM #1) asked what happened and she (MC #1) stated that they were making lunch when [client A] said he had to use the bathroom." -"After 15-minutes she checked on him and found		and operational standards. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	

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	he had eloped from his bedroom window...". -"...I (RM #1) drove there and searched the area then hospital staff called me around 1:45pm and said [client A] was there." -"I (RM #1) went to the hospital and picked him (client A) up at 1:50pm...". -"...Factual Findings...". -"...[MC #1] last saw [client A] at 11:55am." -"15 minutes later at 12:10pm [MC #1] checked on [client A], per his plan and discovered he had eloped." -"[RM #1] was notified that [client A] at (sic) the hospital around 1:45pm." -"[RM #1] went to the hospital at 1:50pm and she picked him up an hour later and transported him home...". -"...The home is to be double-staffed and there was only one staff present during the incident...". -"...Conclusion." -"1) It is substantiated that [client A] (individual) eloped from the home, approximately 55 minutes, because he was upset [MC #1]...[Client A] told him not to elope again and that upset him so he left the home." -"2) It is unsubstantiated that staff followed ResCare Policy and Procedure appropriately." -"Recommendations...".			

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	-"...It is recommended that the home be double-staffed at all times, per protocol...". A review of the IS dated 1/16/20 indicated client A eloped from the group home after asking staff to use the restroom. The review indicated client A eloped through his bedroom window. The review indicated client A was out of staff supervision for approximately 55 minutes. The review indicated MC #1 stated she was the only staff on duty. The review indicated the investigator interviewed a second staff (staff #1) who indicated he was at the group home working at the time of the incident. The review indicated the investigator stated in her recommendations for the home to be double-staffed per protocol. The review did not indicate a thorough investigation completed by the investigator clarifying which staff were actually working at the time of the incident. -A BDDS report dated 1/19/20 indicated, "...On 1/18/20, [client A] had gone to sleep in his room and was receiving 15-minute checks per his plan. During a routine check, staff discovered [client A] was not in bed as noted during the last 15 minute check. Staff was unable to locate [client A] after immediately checking different areas inside the home and the outside perimeters of the home. It was discovered that [client A] climbed out of his bedroom window (turning off the window alarm). Staff immediately went to investigate and located [client A] at the [name of gas station]...Please note that [client A] was out of staff's line of sight for no more than 30 minutes...". A review of the BDDS report dated 1/19/20 indicated client A eloped from the home on 1/18/20. The review indicated client A eloped through his bedroom window and turned off the window alarm. The review indicated client A was			

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	out of staff's line of sight for 30 minutes. -An IS dated 1/23/20 indicated the following: -"...Investigative Summary...". -"...Investigator(s) / Title(s) [QAC #1]...". -"...Introduction." -"On 1.18.20 at 6:45PM [client A] (individual) [client A (sic)] was in his bedroom taking a nap then [staff #1] completed routine 15-minute checks on [client A] when he (staff #1) discovered [client A] was not in his bedroom. [Client A's] bedroom window was open and the window alarm was disabled. [Staff #1] immediately searched for him in the home and notified the supervisor. [Staff #1] searched the neighborhood and located [client A] at the [name of gas station]. [Client A] was out of staff's sight for approximately less than 30 minutes...". -"...Scope of Investigation." -"1) Why did [client A] (individual) elope from the home for approximately less than 30 minutes?" -"2) Did staff follow ResCare Policy and Procedures appropriately?...". -"...Summary of Interviews...". -"...[Client A]...". -"...Why did you (client A) elope from the home?" -"I (client A) just wanted to leave." -"I know how to take the alarm off the window and			

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	I put it under the mattress." -"I take the screen out and put it under my mattress...". -"...[Staff #1]...". -"...[Client A] was sleeping in his room." -"Staff (I (staff #1)) did my progress notes and then checked on him only to see that he was not present in his room." -"His (client A) bedroom window was open; it was around 6:45pm." -"Staff (I (staff #1)) was advised to take the van and look for him." -"I found [client A] around 7:30pm at the [name] down the street...". -"...[Staff #4]...". -"...Immediately after dinner at 5:30pm, [client A] went to his room to take a nap; staff followed him and observed him lay down in his bed." -"Staff kept checking on him and completing 15-minute checks through 6:30pm." -"At 6:45pm when staff went back to check on him, for the 15-minute check, [client A] was not on his bed." -"Staff checked everywhere in the house and noticed the window in his room was open...". -"...Factual Findings."			

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	-"[Staff #1] last saw [client A] at 6:45pm." -"15 minutes later at 7pm [staff #1] check on [client A], per his plan and discovered he had eloped." -"[Staff #1] searched for [client A] and located him around 7:30pm...". -"...Conclusion." -"1) It is substantiated by his (client A's) own admission, that [client A] (individual) eloped from the home from the home (sic) for approximately 30 minutes because he "wanted to." -"2) It is substantiated that staff followed ResCare Policy and Procedures appropriately...". A review of the IS dated 1/23/20 indicated client A eloped from the home on 1/18/20. The review indicated client A eloped through his bedroom window and disabled the window alarm. The review indicated, in staff #1's interview summary, staff #1 at around 6:45 PM found client A's bedroom window open and client A not present. The review indicated, in staff #4's interview summary, staff kept checking on client A and completing 15 minute checks through 6:30 PM and at 6:45 PM when staff went back to check on client A, client A was not in his bed. The review indicated, in the factual findings, staff #1 last saw client A at 6:45 PM. The review indicated the investigator did not complete a thorough investigation due to contradiction of factual findings to the statements provided by staff regarding the last time client A was seen by staff prior to elopement. QAC (Quality Assurance Coordinator) #1 was			

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	interviewed on 2/24/20 at 1:55 PM. QAC #1 was asked if the factual findings and conclusions of the investigation (investigation completed on 1/16/20) into client A's elopement on 1/12/20 indicated the home was to be double-staffed and there was only one staff present during the incident. QAC #1 stated, "Yes." QAC #1 was asked if the investigation included an interview with a second staff who indicated they were working at the home at the time of the incident on 1/12/20. QAC #1 stated, "Yes." QAC #1 was asked if the investigation into client A's elopement on 1/12/20 should have indicated only one staff were present during the incident, when it (the investigation) has a statement from a second staff indicating their attendance during the incident. QAC #1 stated, "No, I should have clarified statements." QAC #1 was asked what time, according to the investigation, was client A discovered to be missing from his room during the incident of client A's elopement on 1/18/20. QAC #1 stated, "6:45 PM." QAC #1 was asked if the investigation's factual findings into client A's elopement on 1/18/20 should have indicated the last time client A was seen by staff was at 6:45 PM if the summary of interviews in the investigation indicated staff statements from two staff stating client A was discovered missing from his room at 6:45 PM. QAC #1 stated, "No." QAC #1 was asked if the factual findings in the investigation into client A's elopement on 1/18/20 should have indicated staff went to complete a 15 minute check on client A at 7:00 PM when their were statements from two staff indicating client A was missing from the group home at 6:45 PM. QAC #1 stated, "No." 2. A BDDS report dated 2/12/20 indicated, "...On the night of 12/11/20 (sic), while visiting a ResCare waiver home...staff observed [client F] hiding a			

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	valve from an air mattress in her hand. Staff observed that she (client F) had used the valve to scratch her right wrist. Staff redirected [client F] verbally and she provided the object to staff...Staff observed a variety of activities and she began watching television with staff and remained calm for 1.5 hours. At 12:15 AM, [client F] stood up and began pacing, (sic) Staff provided verbal redirection and [client F] began to escalate. She (client F) exited the house and staff lost line of sight, due to not being able to leave because other individuals were asleep in the home...It should be noted that [client F] does not have plan approved alone time...". A review of the BDDS report dated 2/12/20 indicated client F eloped from the group home. The review indicated only one staff was on duty during the elopement incident. The review did not indicate a completed investigation into the elopement of client F on 2/11/20. QIDPM (Qualified Intellectual Disabilities Professional Manager) #1 was interviewed on 2/26/20 at 1:55 PM. QIDPM #1 was asked if the facility had documentation of a completed investigation regarding the elopement of client F on 2/11/20. QIDPM #1 stated, "We have double checked and cannot locate it." This federal tag relates to complaint #IN00318381. 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 3 sampled clients (client A), the facility failed to	W 0157	**CORRECTION:** *If the alleged violation is verified,*	03/29/2020

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	ensure client A's protective measures were being followed. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 2/21/20 at 10:41 AM. -A BDDS report dated 1/13/20 indicated, "...On 1/12/2020 while preparing lunch with staff and other housemates, [client A] told staff he wanted to use the bathroom. Staff checked on [client A] after 15 minutes, per his plan and discovered that he had eloped from the house, going out by opening the window in his room and removing the screen. Staff immediately informed supervisors and a search for [client A] commenced immediately. [Client A] was located at [name of hospital] Emergency Department...[Client A] was without ResCare staff supervision for approximately 55minutes (sic)...[Client A] is a new admission to the house and was (sic) 15-minute checks per new admission protocol and does not have approved alone time...Additional protective measures put in place include line of sight observations during waking hours in addition to continuing 15-minutes checks while sleeping...". A review of the BDDS report dated 1/13/20 indicated client A eloped from the group home on 1/12/2020. The review indicated client A was without ResCare staff supervision for approximately 55 minutes. The review indicated client A was on 15 minute checks. -A BDDS report dated 1/19/20 indicated, "...On 1/18/20, [client A] had gone to sleep in his room and was receiving 15-minute checks per his plan. During a routine check, staff discovered [client A]		*appropriate corrective action must be taken.* Specifically, the following protective measures are in place: Specifically, all facility direct support and supervisory staff will be retrained on proper implementation of each client's Behavior Support Plan, including client A's enhanced supervision protocols. **PREVENTION:** When incidents occur, The QIDP Manager will coordinate with the trained investigator and QIDP, through the investigation and corrective measure implementation process, to assure staff are trained to implement protective measures as written. The Residential Manager will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor implementation of behavior supports as written. 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 daily administrative monitoring during varied shifts/times. After 30 days, administrative monitoring will occur no less than weekly until all	

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	was not in bed as noted during the last 15 minute check. Staff was unable to locate [client A] after immediately checking different areas inside the home and the outside perimeters of the home. It was discovered that [client A] climbed out of his bedroom window (turning off the window alarm). Staff immediately went to investigate and located [client A] at the [name of gas station]...Please note that [client A] was out of staff's line of sight for no more than 30 minutes. [Client A] will continue to receive line of sight observation during waking hours and 15-minute checks while sleeping...". A review of the BDDS report dated 1/19/20 indicated client A eloped from the home on 1/18/20. The review indicated client B eloped through his bedroom window and turned off the window alarm. The review indicated client B was out of staff's line of sight for 30 minutes. The review indicated client A's supervision level indicated 15 minute checks. -An IS (Investigative Summary) dated 1/23/20 indicated the following: -"...Investigative Summary...". -"...Investigator(s) / Title(s) [QAC (Quality Assurance Coordinator) #1]...". -"...Introduction." -"On 1.18.20 at 6:45PM [client A] (individual) [client A (sic)] was in his bedroom taking a nap then [staff #1] completed routine 15-minute checks on [client A] when he (staff #1) discovered [client A] was not in his bedroom. [Client A's] bedroom window was open and the window alarm was disabled. [Staff #1] immediately searched for him in the home and notified the supervisor. [Staff		staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Administrative Monitoring is defined as follows: · 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 Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to assuring implementation of protective measures and Behavior Support Plans as written. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential	

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	#1] searched the neighborhood and located [client A] at the [name of gas station]. [Client A] was out of staff's sight for approximately less than 30 minutes...". -"...Scope of Investigation." -"1) Why did [client A] (individual) elope from the home for approximately less than 30 minutes?" -"2) Did staff follow ResCare Policy and Procedures appropriately?...". -"...Summary of Interviews...". -"...[Client A]...". -"...Why did you (client A) elope from the home?" -"I (client A) just wanted to leave." -"I know how to take the alarm off the window and I put it under the mattress." -"I take the screen out and put it under my mattress...". -"...[Staff #1]...". -"...[Client A] was sleeping in his room." -"Staff (I (staff #1)) did my progress notes and then checked on him only to see that he was not present in his room." -"His (client A) bedroom window was open; it was around 6:45pm...". -"I found [client A] around 7:30pm at the [name] down the street...".		Manager, Direct Support Staff, Operations Team, Regional Director	

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-"...[Staff #4]...".

-"...Immediately after dinner at 5:30pm, [client A] went to his room to take a nap; staff followed him and observed him lay down in his bed...".

-"At 6:45pm when staff went back to check on him, for the 15-minute check, [client A] was not on his bed."

-"Staff checked everywhere in the house and noticed the window in his room was open...".

-"...Conclusion."

-"1) It is substantiated by his (client A's) own admission, that [client A] (individual) eloped from the home from the home (sic) for approximately 30 minutes because he "wanted to."

-"2) It is substantiated that staff followed ResCare Policy and Procedures appropriately...".

A review of the IS dated 1/23/20 indicated client A eloped from the home on 1/18/20. The review indicated client A eloped through his bedroom window and disabled the window alarm. The review indicated client A was out of staff's sight for approximately 30 minutes. The review indicated client A's supervision level was to include 15 minute checks.

-A BDDS report dated 1/26/20 indicated, "...On 1/25/2020, while staff were attending to [client A's] housemates, [client A] eloped from the house and walked towards the railroad tracks while staff followed him offering support and redirection back to the house. The police were passing by and stopped to redirect [client A], but he became

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	physically aggressive towards the police and he was placed in handcuffs and brought back to the house. Staff spoke with the police and he was released to staff back into the house. [Client A] continued to be verbally aggressive all evening, and became physically aggressive towards staff and punched staff in the face to run away from the house a second time. Staff informed supervisor and a search was initiated for [client A]. [Client A] returned to the house on his own...he was without ResCare supervision for approximately three hours...". A review of the BDDS report indicated client A eloped from the house and walked towards the railroad tracks while staff followed him offering support and redirection. The review indicated client A returned to the home. The review indicated after returning home, client A became verbally and physically aggressive towards staff and punched staff in the face. The review indicated client A then eloped from the house a second time. The review indicated client A returned home on his own from his second elopement. The review indicated client A was without ResCare supervision, during his second elopement, for approximately three hours. -An IS dated 1/31/20 indicated the following: -"...Investigative Summary...". -"...Investigator(s) / Title(s) [QAC #1]...". -"...Introduction." -"On 1.25.20 at 3:30 PM, while [staff #1] attended to [client A's] (individual) housemates [client A] eloped from the home. [Client A] walked to the railroad tracks. [Staff #1] followed and verbally			

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	redirected him back to the home, staff did not lose sight. [Staff #1] notified the supervisor. The police were patrolling and discovered the incident while in progress. The police stopped [client A]. [Client A] became physically aggressive toward the police. The police handcuffed [client A] and escorted him back to the home. Once home, [client A] continued to be verbally and physically aggressive toward [staff #2] for the remainder of the evening. At 6:45PM [client A] punched [staff #2] in the face and ran out the home. [Staff #2] followed [client A] and notified the supervisor. [Client A] returned to the home on his own. [Client A] eloped from the home for approximately 3 hours...". -"...Scope of Investigation." -"1) Why did [client A] (individual) elope from the home at 3:30 PM; never out of staff's sight?" -"2)Why did [client A] (individual) elope from the home at 6:45 PM for approximately 3 hours. (sic)?...". -"...4) Did staff follow ResCare Policy and Procedures appropriately?...". -"...Summary of Interviews...". -"...[Client A]...". -"...Why did you elope at 3:30pm?" -"[Staff #1] upset me." -"What did he do upset you?" -"I don't like people telling me what to do...".			

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	-"...Why did you elope at 6:45pm and punch [staff #2]?" -"Because he told me to sit down." -"Why did you elope after you punched him?" -"That just how I am." -"I left to calm down...". -"...[Staff #1]...". -"...What were you (staff #1) doing/which individuals were you assisting when [client A] eloped at 3:30pm?" -"I (staff #1) followed him and he was in line of sight...". -"...[Staff #2]...". -"...We were in the doorway of the office and he (client A) punched me (staff #2)." -"Then he eloped out the front door...". -"...Factual Findings." -"At 3:30pm [client A] walked out the home...Staff never lost sight of him." -"At 6:45pm [client A] eloped from the home and [staff #2] followed but lost sight of [client A]." -"[Client A] returned home on his own around 9:45pm...". -"...Conclusion."			

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	-"1) It is substantiated, by his (client A's) own admission, that [client A] (individual) eloped from the home at 3:30 PM (never our (sic) of staff's sight) because [staff #1] upset him because he gave him instructions and [client A] did not like when 'people tell him what to do.'" -"2) It is substantiated, by his (client A's) own admission, that [client A] (individual) eloped from the home at 6:45 PM for approximately 3 hours to calm down after [staff #2] told him to sit down...". -"...Recommendations...". -"...It is recommended that [client A] (individual) be placed on one-to-one staff supervision at all times...". A review of the IS dated 1/31/20 indicated client A eloped from the group home on 1/25/20 at 3:30 PM. The review indicated client A did not lose sight of him during the elopement. The review indicated client A eloped for a second time at 6:45 PM. The review indicated staff lost sight of client A during the second elopement. The review indicated client A returned home on his own. The review indicated client A was out of sight of ResCare staff for 3 hours. The review indicated a recommendation client A be placed on one-to-one staffing supervision all at times. -A BDDS report dated 2/6/20 indicated, "...On 2/5/2020, [client A] had gone to sleep and was receiving 15-minute checks per his plan. During a routine check, staff discovered [client A] was not in bed as noted during the last 15-minute check at 1:15am. Staff was unable to locate [client A] and checked different areas inside the home and the outside perimeters of the home. It was discovered that [client A] climbed out of his bedroom window			

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	(turning off the window alarm). Staff informed the supervisor immediately and a search for [client A] started. A missing person report was also filed with the police. [Client A] was found walking back on [name] street walking back to the house by staff...he was without ResCare supervision for approximately 7 hours...The interdisciplinary team has decided additional protective measures to include line of sight 24 hours of the day and the agency is researching an enhanced security system to be installed in the house...". A review of the BDDS report dated 2/6/20 indicated client A eloped on 2/5/20. The review indicated client A eloped through his bedroom window and disarmed the window alarm. The review indicated client A was without ResCare supervision for approximately 7 hours. The review indicated client A's supervision included 15 minute checks. The review indicated client A's interdisciplinary team decided to implement an additional protective measure to include line of sight 24 hours of the day. -An IS dated 2/10/20 indicated the following: -"...Investigative Summary...". -"...Investigator(s) / Title(s) [QAC #1]...". -"...Introduction." -"On 2.5.20 at 1:30AM [client A] (individual) had gone to sleep in his bedroom. [Staff #2] and [staff #5] completed 15-minute checks, per his (client A's) plan. [Staff #2] check on him at 1:15am. Around 1:20am [staff #2] heard [client A's] bedroom window alarm sounding. [Staff #5] ran to the bedroom and discovered that [client A] was not in his bed and observed his bedroom window			

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	open. [Staff #5] observed that the bedroom window alarm was disarmed. [Staff #2] and [staff #5] searched the home. [Staff #2] search (sic) the outside perimeters of the home and notified the (sic) [RM #1]. [RM #1] notified 911 and a police report was made. Around 8:30pm (sic) [RM #1] located [client A] walking on [name of street]; he was walking back to the home...[Client A] was out of staff's sight for approximately 7 hours...". -"...Scope of Investigation." -"1) Why did [client A] (individual) elope from the home for approximately 7 hours?" -"2) Did staff follow ResCare Policy and Procedures appropriately?...". -"...Summary of Interviews...". -"...[Client A]...". -"...Why did you elope?" -"Staff made me upset...". -"That's why I eloped. (because staff is telling me what to do)." -"I break the alarm off and put it under the mattress." -"I took the screen out of the window and put it under my mattress...". -"...[Staff #2]...". -"...[Client A] was asleep in his room at 1:15am." -"Therefore, I was in the med (medication) room			

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	faxing med audits and the other staff ([staff #5]) was in the kitchen doing cleaning." -"When I heard the alarm from [client A's] room the other staff ([staff #5]) immediately rushed to his room and discovered that [client A] had eloped from this (sic) window." -"We immediately started searching for him with (sic) and called [RM #1]...". -"...[Staff #5]...". -"...At around 1:15am staff checked on [client A] in his room but before 1:15am he was restless going and coming out." -"The other staff ([staff #2]) was faxing the med audits we completed while (sic) in the dining room deep cleaning." -"Around 1:20am we heard the alarm from [client A's] window." -"We ran to see what was going on." -"We realized [client A] had ran (sic) out of the window." -"[Staff #2] followed him and ran after him...". -"...[RM #1]...". -"...[Staff #2] was in the med room doing the med audit when [client A] eloped." -"The other staff was doing deep cleaning in the kitchen." -"They heard the alarm and [staff #2] saw [client			

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	A] outside so he ran after him." -"[Client A] took the alarm off but not the sensor so they (staff) were able to hear the alarm." -"I (RM #1) found [client A] walking on [name of street] and he was walking back to the home." -"Factual Findings." -"[Staff #2] last saw [client A] at 1:15am." -"Around 1:20am [staff #2] heard [client A's] window alarm and [staff #5] discovered he had eloped...". -"Around 8:30pm (sic) [RM #1] located [client A] and redirected him to get in the van and transported him home." -"[Client A] was out of staff's sight for approximately 7 hours...". -"...Conclusion." -"1) It is substantiated that [client A] (individual) eloped from the home for approximately 7 hours because he was upset...". A review of the IS dated 2/10/20 indicated client A eloped from the home on 2/5/20. The review indicated client A eloped out of his bedroom window. The review indicated client A was without ResCare staff supervision for approximately 7 hours. Client A's record was reviewed on 2/24/20 at 12:35 PM. -A 15 minute check tracking sheet for client A			

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	dated 1/12/2020 indicated no documentation by staff of the 15 minute tracking being completed between 8:15 AM through 3:45 PM. The review did not indicate documentation of the 15 minute checks being completed as was indicated by staff to have been occurring during the time of the elopement incident involving client A on 1/12/20. -A 15 minute check tracking sheet for client A dated 1/18/20 indicated staff #4 documented a completion of 15 minute checks for client A between 3:30 PM through 9:45 PM. The review indicated staff #4 documented, on the 15 minute check tracking sheet, client A was awake and in the living from from 6:45 PM through 7:30 PM. The review indicated documentation by staff #4 of client A's location to be awake and in the living room from 6:45 PM through 7:30 PM, compared to the Investigative Summary dated 1/23/20 which indicated client A had eloped from the home at 6:45 PM and was located outside the home at 7:30 PM by staff #1 on 1/18/20. -A 15 minute check tracking sheet for client A dated 1/25/20 indicated no documentation by staff of the 15 minute check being completed between 3:30 PM through 7:45 PM. The review indicated staff #2 documented, on the 15 minute check tracking sheet, client A was awake and in the living room from 8:00 PM through 11:45 PM. The review indicated documentation by staff #2 of client A's location to be awake and in the living room from 8:00 PM through 9:30 PM, compared to the Investigative Summary dated 1/31/20 which indicated client A had eloped from the home at 6:30 PM and did not return to the home until 9:30 PM on 1/25/20. -A 15 minute check tracking sheet for client A dated 2/5/20 indicated staff #2 documented a			

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	15G465	A. BUILDING 00 B. WING	02/28/2020

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	completion of 15 minute checks for client A between 12:00 AM through 8:00 AM. The review indicated staff #2 documented client A was awake and in his bedroom from 12:00 AM through 6:30 AM. The review indicated staff #2 documented client A was awake and in the living room from 6:45 AM through 8:00 AM. The review indicated documentation by staff #2 of client A's location to be awake and in his bedroom from 1:15 AM through 6:30 AM and awake and in the living room from 6:45 AM through 8:00 AM, compared to an Investigative Summary dated 2/10/20 which indicated client A had eloped out of the group home at 1:20 AM and did not return to the group home until 8:30 AM. QIDPM (Qualified Intellectual Disabilities Professional Manager) #1 was interviewed on 2/24/20 at 1:55 PM. QIDPM #1 was asked about client A's supervision level on 1/12/20. QIDPM #1 indicated client A was on 15 minute checks, 24 hours a day, 7 days a week, due to being a new admission. QIDPM #1 was asked if staff should have documented on the 15 minute check tracking sheet client A's location to be in the group home during the times when the BDDS reports and investigation indicate client A to have been out of the home due to elopement. QIDPM #1 indicated they should not. QIDPM #1 was asked if staff should have documented on the 15 minute check tracking sheet the location of client A to be at home (either in the living room or in his bedroom) during times indicated in investigations of elopements (elopements on 1/18/20, 1/25/20, and 2/5/20) where client A was indicated to have been out of the home due to eloping. QIDPM #1 indicated the documentation should not have been done. This federal tag relates to complaint #IN00318381.			

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	9-3-2(a)			
W 0186 Bldg. 00	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on record review and interview for 1 additional client (client F), the facility failed to ensure sufficient staff were present to prevent the elopement of client F. Findings include: The facility's BDDS (Bureau of Developmental Disabilities) reports and investigations were reviewed on 2/21/20 at 10:41 AM. -A BDDS report dated 2/12/20 indicated, "...On the night of 12/11/20 (sic), while visiting a ResCare waiver home...staff observed [client F] hiding a valve from an air mattress in her hand. Staff observed that she (client F) had used the valve to scratch her right wrist. Staff redirected [client F] verbally and she provided the object to staff...Staff observed a variety of activities and she began watching television with staff and remained calm for 1.5 hours. At 12:15 AM, [client F] stood up and began pacing, (sic) Staff provided verbal redirection and [client F] began to escalate. She (client F) exited the house and staff lost line of sight, due to not being able to leave because other individuals were asleep in the home...It	W 0186	**CORRECTION:** *The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.* Specifically, the Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than two staff on duty between 24/7, with additional staffing resources to be made available, based on acute need. Additionally, when clients are visiting other ICF or Waiver homes, pending transition, the facility will provide direct support staff at the location of the visit to assure required staffing ratios are in place. When direct support personnel are unavailable to provide coverage as described above, salaried supervisory staff will fill in, providing direct support as needed. **PREVENTION:**	03/29/2020

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	should be noted that [client F] does not have plan approved alone time...". A review of the BDDS report dated 2/12/20 indicated client F, while visiting a ResCare waiver home, obtained a valve from an air mattress and used the valve to scratch her right wrist. The review indicated client F provided the valve to staff after verbal redirection. The review indicated client F eloped from the group home. The review indicated only one staff was on duty during the elopement incident. The review did not indicate a completed investigation into the elopement of client F on 2/11/20. Client F's record review was on 2/24/20 at 10:22 AM. -Client F's BSP (Behavioral Support Plan) dated November 2019 indicated the following: -"...Consumer: [client F]...". -"...Plan Date: November 2019...". -"...History...". -"...She (client F) will make any number of items she may find in the home a weapon and attempt to try to cut herself...". -"...Target Behaviors & Goals...". -"...Elopement: Any instance in which she leaves the area that she is supposed to be present, takes it upon herself to leave without telling staff members where she is going...". -"...Self-Injurious Behavior: This includes but is not limited to head banging, cutting, hair pulling,		Each evening for the next 90 days, the Residential Manager will submit a list of scheduled staff with their assigned hours, for the following day. The list will be reviewed by the Area Supervisor, Program Manager, Operations Manager, Quality Assurance Manager and QIDP Manager. Administrative staff will direct the team, making adjustments as needed. After 90 days, the Operations Manager and Quality Assurance Manager will determine the level of monitoring necessary to assure appropriate coverage. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Area Supervisors, Quality Assurance Coordinators, Nurse Manger Assistant Nurse Manager) will conduct daily administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios. After 30 days administrative monitoring will occur no less than weekly, until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility.	

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	putting self in dangerous situations, or any attempt to harm self...". -"...Rights Restrictions: The team has reviewed the risks for each of the below stated rights restrictions and agrees that the restrictions should be implemented as stated to ensure health and safety for all person in the environment...". -"...Restrictions...". -"...Sharps (Knives forks, scissors, etc.)...". -"...Line of Sight...". -"...Risks to Individual...". -"...[Client F] will engage in self harm and extreme physical aggression towards staff when these items are present...". -"...[Client F] will walk or run away from staff members or she will engage in physical aggression when she is around her housemates...". -"...Plan to Restore Rights...". -"...All of these items should be removed from the home or placed in a locked area where [client F] does not have access...". -"...Staff needs to make sure they can see the consumer at all times due to her target behaviors...". A review of client F's BSP dated November 2019 indicated client F had a history of making any number of items she may find in the home a weapon and attempted to try to cut herself. The		Administrative Monitoring is defined as follows: · 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 Administrative support at the home will include assuring adequate direct support staff are on duty to meet the needs of all clients. The Quality Assurance Manager and QIDP Manager or other designated Quality Assurance staff will perform spot checks of attendance records to assure ongoing compliance. If deficiencies are noted, the QA staff will notify the Program Manager, Operations Manager and Executive Director to assure prompt corrective action. Prior to each schedule period, the Operations Team will follow-up	

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	review indicated client F had target behaviors and goals for elopement and self-injurious behavior. The review indicated client F had a right restriction for sharps and a right restriction for line of sight. QIDPM #1 was interviewed on 2/24/20 at 1:55 PM. QIDPM #1 was asked if all staff at the ResCare waiver home were trained regarding client F's BSP/risk plans prior to the overnight visit on 2/11/20. QIDPM #1 stated, "Yes." QIDPM #1 was about client F's level of supervision. QIDPM #1 indicated client F was line of sight during waking hours and 15 minute checks while sleeping. QIDPM #1 was asked if client F eloped from the ResCare Waiver home on 2/11/20. QIDPM #1 stated, "Yes." QIDPM #1 was asked about the number of staff working when client F eloped from the home on 2/11/20. QIDPM #1 stated, "One." QIDPM #1 was asked if more than one staff should have been present at the time of client F's elopement. QIDPM #1 stated, "To meet the staffing requirements there should have been two staff." QIDPM #1 was asked if only one staff working at the group home with multiple clients cam meet the requirements needed to provide client F's supervision level and prevent elopements of client F. QIDPM #1 stated, "No." 9-3-3(a)		verbally and via email to assure that appropriate coverage has been arranged. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, BDDS Generalist, Regional Director	
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the			

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	individual program plan. Based on record review and interview for 1 additional client (client F), the facility failed to ensure client F's BSP (Behavioral Support Plan) was followed as written. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 2/21/20 at 10:41 AM. -A BDDS report dated 2/12/20 indicated, "...On the night of 12/11/20 (sic), while visiting a ResCare waiver home...staff observed [client F] hiding a valve from an air mattress in her hand. Staff observed that she (client F) had used the valve to scratch her right wrist. Staff redirected [client F] verbally and she provided the object to staff...Staff observed a variety of activities and she began watching television with staff and remained calm for 1.5 hours. At 12:15 AM, [client F] stood up and began pacing, (sic) Staff provided verbal redirection and [client F] began to escalate. She (client F) exited the house and staff lost line of sight, due to not being able to leave because other individuals were asleep in the home...It should be noted that [client F] does not have plan approved alone time...". A review of the BDDS report dated 2/12/20 indicated client F, while visiting a ResCare waiver home, obtained a valve from an air mattress and used the valve to scratch her right wrist. The review indicated client F provided the valve to staff after verbal redirection. The review indicated client F eloped from the group home. The review indicated only one staff was on duty during the elopement incident. The review did not indicate a completed investigation into the elopement of	W 0249	**CORRECTION:** *As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.* Specifically, client F no longer lives at the facility. All facility direct support and supervisory staff will be retrained on proper implementation of each client's Behavior Support Plan. Additionally, when clients are visiting other ICF or Waiver homes, pending transition, the facility will provide training to direct support staff at the location of the visit to facilitate proper implementation of behavior supports. **PREVENTION:** The facility's QIDP will be trained regarding the need to assure aggressive and consistent implementation of active treatment for all clients, including proper implementation of behavior supports, including during transition visits. The Residential Manager will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist	03/29/2020

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	client F on 2/11/20. Client F's record review was on 2/24/20 at 10:22 AM. -Client F's BSP (Behavioral Support Plan) dated November 2019 indicated the following: -"...Consumer: [client F]...". -"...Plan Date: November 2019...". -"...History...". -"...She (client F) will make any number of items she may find in the home a weapon and attempt to try to cut herself...". -"...Target Behaviors & Goals...". -"...Elopement: Any instance in which she leaves the area that she is supposed to be present, takes it upon herself to leave without telling staff members where she is going...". -"...Self-Injurious Behavior: This includes but is not limited to head banging, cutting, hair pulling, putting self in dangerous situations, or any attempt to harm self...". -"...Rights Restrictions: The team has reviewed the risks for each of the below stated rights restrictions and agrees that the restrictions should be implemented as stated to ensure health and safety for all person in the environment...". -"...Restrictions...". -"...Sharps (Knives forks, scissors, etc.)...".		with and monitor implementation of behavior supports as written. 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 daily administrative monitoring during varied shifts/times. After 30 days, administrative monitoring will occur no less than weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Administrative Monitoring is defined as follows: · 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	

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	-"...Line of Sight...". -"...Risks to Individual...". -"...[Client F] will engage in self harm and extreme physical aggression towards staff when these items are present...". -"...[Client F] will walk or run away from staff members or she will engage in physical aggression when she is around her housemates...". -"...Plan to Restore Rights...". -"...All of these items should be removed from the home or placed in a locked area where [client F] does not have access...". -"...Staff needs to make sure they can see the consumer at all times due to her target behaviors...". A review of client F's BSP dated November 2019 indicated client F had a history of making any number of items she may find in the home a weapon and attempted to try to cut herself. The review indicated client F had target behaviors and goals for elopement and self-injurious behavior. The review indicated client F had a right restriction for sharps and a right restriction for line of sight. QIDPM #1 was interviewed on 2/24/20 at 1:55 PM. QIDPM #1 was asked if client F, while visiting a ResCare Waiver home on 2/11/20, obtained a valve from air mattress and utilized it to scratch herself. QIDPM #1 stated, "Yes." QIDPM #1 was asked if client F had a sharps restriction implemented in her BSP. QIDPM #1 stated, "Yes."		observation is the top priority. · Review all relevant documentation, providing documented coaching and training as needed Administrative support at the home will include Assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to assuring implementation Behavior Support Plans as written. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Direct Support Staff, Operations Team, Regional Director	

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	QIDPM #1 was asked if client F should have been able to obtain a valve to scratch herself. QIDPM #1 stated, "No." QIDPM #1 was asked if all staff at the ResCare waiver home were trained regarding client F's BSP/risk plans prior to the overnight visit on 2/11/20. QIDPM #1 stated, "Yes." QIDPM #1 was about client F's level of supervision. QIDPM #1 indicated client F was line of sight during waking hours and 15 minute checks while sleeping. QIDPM #1 was asked if client F eloped from the ResCare Waiver home on 2/11/20. QIDPM #1 stated, "Yes." QIDPM #1 was asked about the number of staff working when client F eloped from the home on 2/11/20. QIDPM #1 stated, "One." QIDPM #1 was asked if more than one staff should have been present at the time of client F's elopement. QIDPM #1 stated, "To meet the staffing requirements there should have been two staff." QIDPM #1 was asked if only one staff working at the group home with multiple clients cam meet the requirements needed to provide client F's supervision level and prevent elopements of client F. QIDPM #1 stated, "No." 9-3-4(a)			