STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 00 B. WING	06/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	13009 HORIZON DR MEMPHIS, IN 47143

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W 0000 Bldg. 00	This visit was for the investigation of Complaint #IN00230822. Complaint #IN00230822: Substantiated, Federal/State deficiency related to the allegation is cited at W149. Survey dates: May 25, 26 and June 2, 2017. Facility Number: 004615 Provider Number: 15G723 AIM Number: 200528230 This federal deficiency reflects state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 6/19/17.	W 0000		
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 2 of 2 sampled clients (A	W 0149	**W149:** That facility must	07/02/2017

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 determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	and B), and for 8 of 10 investigations of abuse/neglect reviewed, the facility failed to ensure the facility's neglect/abuse/mistreatment policy was implemented in regard to client to client abuse (physical aggression). Findings include: Observations were conducted at the facility on the evening of May 25, 2017 from 3:15 PM until 6:45 PM. Clients B and C were observed to be at the facility with facility staff #1 and Home Manager/HM #1 from another facility who was helping that evening. Client A was at an inpatient facility due to behaviors. HM #1 indicated (5/25/17 3:25 PM) client D had left the facility for a home visit over the holiday (Memorial Day) weekend. Client C was observed to be lying down in his bedroom, refusing activities. Client B was being supervised by staff #1. Client B repeatedly interrupted the conversation of HM #1 and the surveyor. The facility was observed to have multiple patched wall areas (patched holes) in the east bedroom hallway, client A's bedroom walls and the living room area. Client A's bedroom door was missing and was outside the facility on the ground. The front door's inside facing was absent exposing drywall and nail holes. Interview with		develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. **Corrective Action: (Specific):** All staff working at the home will be re-trained on the Operation Standard for reporting and investigating allegations of abuse neglect exploitation mistreatment or violation of individual's rights. Client A and Client B have been moved to another location. **How others will be identified: (Systemic):** All staff at the home will be re-trained on all individuals BSP's to ensure full understanding. The QIDP will be at the home at least 10 hours weekly to conduct observations, ensure that all individual program plans are implemented as written and that changes are made based in individual need. The behavior clinician will be in the home at least 10 hours per week to ensure that individual program plans are implemented as written and that changes are made based on individual need. **Measures to be put in place:** All staff working at the home will be re-trained on the Operation Standard for reporting and investigating allegations of abuse neglect exploitation mistreatment or violation of individual's rights. Client A and Client B have been moved to another location.	

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	staff #1 (5/25/17 at 3:45 PM) stated the damage to the front door was an "accident." IDTs (Interdisciplinary Team Meetings) dated 5/19/17, 5/21/17 and 5/22/17 were reviewed on 5/26/17 at 4:15 PM. The 5/19/17 IDT held by QIDP #1 (Qualified Intellectual Disabilities Professional) indicated client A had been threatening suicide so suicide precautions (one on one observation by staff) were implemented. The 5/21/17 IDT was held to extend the suicidal precautions via HRC (Human Rights Committee) approval. The 5/22/17 IDT indicated a "Mobile Assessment" (therapist came to the facility to see client A) was completed. The assessment indicated client A should be admitted to inpatient psychiatric care on 5/22/17 at 4:00 PM. The IDT indicated the client's guardian had given consent for this action. The facility's incident reports/IR were reviewed at 4:00 PM on 5/25/17. The facility's Bureau of Developmental Disabilities Services/BDDS reports and investigations were reviewed on 5/26/17 at 2:00 PM and indicated the following: An investigation dated 3/30-31/17 alleged staff #10 had been verbally abusive and had threatened an		**Monitoring of Corrective Action:** All staff at the home will be re-trained on all individuals BSP's to ensure full understanding. The QIDP will be at the home at least 10 hours weekly to conduct observations, ensure that all individual program plans are implemented as written and that changes are made based in individual need. The behavior clinician will be in the home at least 10 hours per week to ensure that individual program plans are implemented as written and that changes are made based on individual need. **Completion date: 07/02/17**	

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	unapproved restraint (take down to floor) of client B. The investigation indicated the allegations of verbal abuse/threats were substantiated. Staff #10 was terminated from employment. 5/5/17 at 6:30 PM, client A was being verbally aggressive with other clients and the staff. He went to his room to calm and came out asking for the phone. He used the phone and dialed 911. Client A told the dispatcher he was suicidal and hung up before staff could explain anything. The police came to the facility to ensure everyone was safe. 5/13/17 at 5:00 PM, client A was using the phone in his bedroom when client B wanted the phone. Client B ran into client A's room and client A hit client B. Client A eloped from his bedroom window. Police were called, staff followed client A keeping him in sight. Police picked up client A and returned him to the facility. 5/15/17 10:00 PM, client B wanted to use the phone to order pizza and was told it was too late. Client B became aggressive and knocked staff to the floor. A single staff implemented YSIS (You're Safe, I'm Safe-agency approved physical restraint/escort methods to manage aggression), and client B hit and bit staff.			

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	Then a two person hold was done. The staff could not control client B so the police were called for assistance and came to the facility. 5/21/17 at 9:00 AM, client A attempted to elope twice. He was picked up in the facility's van and exhibited property destruction and SIB (Self Injurious Behavior). When he was back at the facility, he picked up a hose and sprayed client B with water. The staff applied YSIS. Methods did not calm client A so the police were called. Client A was taken to a local ER (Emergency Room). He was diagnosed with Schizoaffective disorder, told to follow up with his PCP/primary care physician and released back to the facility. Clients B and D engaged in "horseplay." Client B hit client D in the stomach and back. 5/21/17 2:30 (pm) by substitute staff/SS #2 indicated an episode between clients A and B. Client A was outside the facility "punching windows and throwing things at the side of the house. Verbal redirection was futile and client became belligerent." The staff applied YSIS to manage the aggression. Client B was in the area, became verbally aggressive and started hitting client A while he was still in the YSIS hold. The report indicated client A calmed after he was hit. One			

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	staff was able to manage client A while the other worked to calm client B. The incident report indicated "Possible injuries to forehead and wrist" for client A. The QIDP did a "Client to Client Aggression Investigation" regarding the above incident on 5/23/17. The investigation indicated in part #7, "Is there a pattern of occurrence between these two clients? YES, both clients (A and B) antagonize each other daily. They are constantly trying to upset each other and staff are spending the majority of their time dealing with both client's (sic) target behaviors daily." 5/21/17 5:00 PM IR by Area Manager/AM #1 indicated client A was agitated because of another client (B). "They had been into it all day with several incidents." Client B went into the staff's office, slammed the door and took the house phone to his bedroom. YSIS was employed and he bit two staff (unknown) while being restrained. Police (Sheriff's office) were called for assistance. When police arrived, client A started acting up and was handcuffed by the police. Police took client B to (hospital) and staff were told "that he (client B) was calm and didn't require anything." Client B was sent back to the			

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	facility. On 5/26/17 at 2:00 PM a police report regarding the above incident was reviewed. The local Sheriff's Incident Report was dated/timed 5/21/17 5:34:13 PM and indicated it was "Incident Type: Domestic Disturbance" and was called in by client D. The narrative portion of the Sheriff's Incident Report indicated the situation was "physical...one subj (subject) is bleeding...the aggressor is restrained but still fighting..subj is biting..RESCARE refuse any charges be filed or a report to be filed. They did request that yellow EMS transport subject (client B) to [name of hospital] for a Mental Evaluation." 5/21/17 6:45 PM (time report written) IR by SS #3, "[Client A] was flipping furniture and throwing other house items. I asked him to stop his behavior. He ran up to me and started punching me and police officers that were there intervened handcuffing him. Eventually he was released and the police departed. He soon began to break stuff including taking his door off the hinges." The client calmed after one man YSIS hold was applied for 5 minutes by SS #2. The IR indicated, "He (client A) was not injured during the incident, however it was discovered he had inflicted several wounds on his wrist,			

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	they were minor." The cuts were treated with alcohol wipes. The IR indicated EMS (Emergency Medical Services) were present during the incident. Confidential interview #1 indicated clients A and B constantly had behaviors which could culminate in serious injury. The interview stated Client B's behavior was "very aggressive" and the police had been to the facility on numerous occasions to assist staff with him. The interview indicated the two clients should not be in the same living unit. Confidential interview #2 indicated the facility was lucky no serious injuries had occurred with clients A and B as well as staff so far at the facility. Confidential interview #3 indicated clients A and B did not get along and should be separated as far as living facilities. The interview indicated client B had boundary issues and was inappropriate with women, invading their personal space and touching them inappropriately despite redirection. The interview indicated while the therapist was assessing client A at the facility, she was visibly shaking. The interview indicated the therapist was uncomfortable, possibly afraid, of the clients.			

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Interview with QIDP #1 on 5/25/17 at 4:20 PM indicated clients A and B had a personality conflict.
The interview indicated client A was in an inpatient facility for assessment after being on suicide precautions due to threats of harming himself for four straight days.
The interview indicated the agency had policies and procedures which prohibited neglect/abuse/mistreatment of clients.

Additional observations/interviews were done at the facility on the evening of 5/26/17 at 5:30 PM. Client B was not at the facility. A new client (E) was at the facility. He (E) and client B had switched residences earlier that afternoon. Staff #6 indicated staff had gone to get client A who had been released from the inpatient psychiatric facility. The interview indicated switching clients E and B was a good idea and would help client A's behavior. Client E indicated his guardian had approved the move of residence and the move was discussed with him.

The Agency's Operation Standard Reporting and Investigating Abuse, Neglect, Exploitation, Mistreatment and Violation of an Individual's Rights (revised 01/20/2016) was reviewed on 5/26/2017 at 3:30 PM. The policy

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	indicated all allegations would be investigated and addressed. The review indicated the agency prohibited "abuse, neglect, exploitation, mistreatment or violation of an Individual's rights. These include and are defined as any of the following: ...hitting, pinching,...the infliction of physical pain...verbal abuse including screaming, swearing, name-calling, belittling, damaging an Individual's self-respect or dignity...." This federal tag relates to Complaint #IN00230822. 9-3-2(a)			