| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 15G811 | A. BUILDING 00<br>B. WING | 06/02/2015 |

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| W 0000<br><br>Bldg. 00 | This visit was for the investigation of complaint #IN00169157.<br><br>Complaint #IN00169157-Substantiated, Federal/State deficiencies related to the allegations are cited at W149 and W153.<br><br>Survey Dates: 5/20/15 and 6/2/15<br><br>Facility Number: 013405<br>Provider Number: 15G811<br>AIM Number: 201267570<br><br>These deficiencies also reflect state findings in accordance with 410 IAC 16.2-5. | W 0000 | | |
| W 0149<br><br>Bldg. 00 | 483.420(d)(1)<br>STAFF TREATMENT OF CLIENTS<br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.<br>Based on observation, interview and record review for 1 of 18 allegations of abuse, neglect and/or injuries of unknown origin reviewed, the facility failed to implement its written policy and procedures to ensure its facility and/or management staff immediately reported an allegation of verbal abuse and/or mistreatment of client A. | W 0149 | The facility develops and implements written policies and procedures that prohibit mistreatment, neglect and abuse of clients. This includes, but is not limited to immediate reporting of abuse or mistreatment of any client. The facility trains all employees, upon new hire training on all policies. This includes ResCare's Abuse, Neglect and Exploitation training. | 07/02/2015 |

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

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| | Findings include:<br><br>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 5/20/15 at 9:14 AM. The facility's 3/6/15 reportable incident report indicated "On March 6, 2015 a staff member reported that during a YSIS (You're Safe, I'm Safe-physical restraint technique) on [client A], staff member [staff #1] had made a statement to [client A] that he should have thought about being in a hold before he had behaviors. She then placed three towels over his face, as [client A] was spitting. [Client A] stated that he couldn't breathe, [staff #1] then told [client A] that was too bad and that she would remove the towels when he stopped spitting. Another staff member involved told her to remove the towels and she did. [Staff #1] has been suspended pending investigation. All staff currently working have been immediately retrained on ResCare and State policy regarding immediate reporting of abuse or neglect. ResCare supervisors will be in the facility to retrain each staff as they come onto shift, before working on the floor with the clients...."<br><br>The facility's 3/6/15 Investigative Summary indicated the incident | | All employees will complete ResCare's Prevention of Abuse, Neglect and Exploitation training annually. Quality Assurance staff will review and retrain for employee understanding and competency regarding ResCare's Abuse, Neglect and Exploitation policy. This will include recognizing what constitutes abuse, neglect and exploitation, and the immediate reporting requirement. This review will occur, at the All Staff Meetings, held each month. Documentation of employee training will be filed and maintained by ResCare Human Resources. Human Resources will submit documentation to the Executive Director quarterly, for verification that all employees maintain policy standards regarding abuse/neglect/exploitation policies. ResCare QIDP's will conduct active treatment observations, at least three times per week, one on each shift, to provide support and training, as necessary, on the spot, for thirty days. If sufficient evidence exists that policy and procedure is understood and being followed, after thirty days, and ongoing, ResCare QIDP's will conduct active treatment observations weekly. These observations will be recorded on the active treatment observation form, and submitted to the Executive Director for review and plan of | |

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| | regarding client A occurred on 3/2/15 and was not reported until 3/6/15 by staff #2.<br><br>The facility's 3/6/15 investigation indicated the following (not all inclusive):<br><br>-Staff #2's 3/6/15 Confidential Witness Statement Form indicated "On Monday, 3-2-15, I (staff #2) witnessed a staff member become verbally abusive to a client who was at the current time in a YSIS supine hold. 2nd (second) shift [staff #1] said to the client, when he was asking staff to get off his knee, 'You should have thought of that before.' During the same YSIS, she (staff #1) placed 3 towels over his face and when he told her he couldn't breathe she said 'Too bad. I'll take them off when you're done spitting.' Other staff told her to immediately remove the towels and she did so saying 'Fine. You're the one getting spit on."<br><br>-Staff #3's 3/10/15 witness statement Confidential Witness Statement Form indicated staff #3 assisted in the YSIS hold on 3/2/15. Staff #3's witness statement indicated "...While on the floor, [client A] was spitting on the staff holding him. We asked that a towel be placed over [client A's] face to stop him from spitting. During this [staff #1] | | correction, if necessary.Ongoing, ResCare Quality Assurance staff will provide additional support and opportunity for training by conducting at least one weekly active treatment observation. During the course of each month Quality Assurance staff will ensure that there has been at least one observation on each shift. These observations will be recorded on the active treatment observation form. and submitted to the Executive Director for review and plan of correction if necessary. Per ResCare policy, when an allegation of abuse, neglect or exploitation occurs, immediate measures will be taken to protect all clients. ResCare administration and quality assurance staff will complete a thorough investigation and and the appropriate level of corrective action will be taken. The Executive Director will ensure that all investigations are complete, thorough and timely, in order to facilitate any necessary corrective action. Persons responsible: Executive Director, Program Manager, QIDP, Quality Assurance staff Date of completion: 7/2/15 | |

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| | made remarks that were inappropriate to [client A]. [Client A] said he could not breath (sic), and [staff #1] said So, towel not coming off. I (staff #3) do not remember other comments: [staff #1] was pulled aside by RM (Resident manager) [RM #1] about these comments...."<br><br>-Staff #4's 3/9/15 Witness Statement Form indicated client A had been put in a YSIS standing and supine hold. Staff #4's witness statement indicated client A "...continued to kick and spit. The staff put some towels up as a shield to block the spit from hitting them. At one point [staff #1] put a towel over [client A's] face. He stated he could not breathe. [Staff #2] asked [staff #1] to remove the towel and she said 'He will just spit on us.' Again [client A] asked [staff #1] to remove the towel and she said 'Are you going to stop spitting?' [Client A] replied 'No!' [Staff #1] then said 'Well you should have thought about that before you started spitting.' [RM #1] looked at [staff #1] and said '[Staff #1] you can't say things like that.' At that point a staff member removed the towel from [client A's] face...."<br><br>-RM #1's 3/9/15 Confidential Witness Statement Form indicated RM #1 worked the day of the incident. RM #1's witness statement indicated client A was spitting | | | |

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| | at staff while he was being restrained. RM #1's witness statement indicated RM #1 retrieved a dish towel from the kitchen and "...held in mid air between [client A's] face and [staff #5's] head and face so that [client A's] saliva could not reach [staff #5]. [Client A's] (R) (right) arm was bent at the elbow as with his (R) hand. [Client A] was pulling (the dish towel I was holding) down so that he could spit at [staff #5]. [Client A] was angry that I was holding the towel blocking his spitting as he spit straight upward into my face. At this time, [staff #1] squatted down between myself and [staff #5] and I asked [staff #1] to secure [client A's] right hand so that he could not pull down the towel to spit at [staff #5] or her face. [Client A] seemed to stop spitting as I returned to the kitchen to get more towels to wipe the saliva from [client A's] face and for any staff who had [client A's] saliva on their face...." The witness statement indicated the nurse was getting ready to give the client an injection when she returned. RM #1's witness statement did not indicate anything about a towel being placed on client A's face, but did indicate RM #1's witnessing staff #1 making inappropriate statements in regard to client A when he indicated he did not want a shot as it would make his arm sore. RM #1's 3/9/15 witness statement | | | |

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| | indicated staff #1 told client A "You should have thought of that sooner...." RM #1's statement indicated she spoke with staff #1 and told staff #1 her statement was "inappropriate and uncalled for." RM #1's witness statement indicated she did a verbal counseling with staff #1.<br><br>-RM #2's 3/11/15 witness statement indicated "I (RM #2) did not hear about the incident that happened on 3/2/15 until Wednesday 3/4/15 or early Thursday 3/5/15 from [staff #2] via phone @ (at) that point I advised [staff #2] she needed to tell administration as soon as possible."<br><br>The facility's investigation indicated "...Factual Findings: On the evening of March 2, 2015, [client A] was having a heightened anxiety and was having behaviors for most of the evening. He was attempting to strike the nurse and when staff attempted to verbally deescalate [client A], he began spitting on and attempting to strike staff. He was placed in an HRC (Human Rights Committee) approved YSIS as per his BSP (Behavior Support Plan). [Client A] continued spitting. [Staff #1] was not part of the initial YSIS but came to assist the staff after [client A] was in supine position. [Staff #1] placed a towel over | | | |

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| | [client A's] face in an attempt to block him from spitting. [Client A] yelled out that he could not breathe. [Staff #1] told him that he should have thought of that before. She was told by other staff to remove the towel and she did. [Staff #1] was suspended pending investigation and on 3.10.15 tendered her resignation. Resident Managers (RMs), [RM #1] and [RM #2] were given corrective actions as a result of the incident and their failure to report. All staff were required to participate in inservice training regarding reporting policies before working the floor. Conclusion: It is determined that [staff #1] did place a towel over [client A's] face and made a comment to him regarding his actions that was inappropriate. It is further determined that [staff #1's] actions were a direct violation of YSIS training and ResCare policy. Allegations of emotional abuse are substantiated."<br><br>Interview with the Clinical Supervisor (CS) on 5/20/15 at 3:15 PM in regard to the 3/2/15 incident, indicated facility staff should not be placing towels over clients' faces. The CS indicated the 3/2/15 incident was not reported timely to the administrator on 3/2/15 when the incident occurred.<br><br>The facility's policy and procedures were | | | |

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| | reviewed on 5/20/15 at 9:35 AM. The facility's 6/1/13 policy entitled Reporting and Investigating Abuse/Neglect/Exploitation indicated "ResCare strictly prohibits abuse/neglect/exploitation/mistreatment. All employees receive training upon hire regarding definitions/causes of different types of abuse/neglect/exploitation/mistreatment, how to identify abuse/neglect/exploitation/mistreatment, how to report abuse/neglect/exploitation/mistreatment, and what to expect from an investigation. All employees receive this training upon hire and annually, thereafter. Procedures: 1. Any ResCare staff person who suspects an individual is the victim of abuse/neglect/exploitation must immediately notify the Program Manager or Quality Assurance Manager, then complete an Incident Report. The Program Manager will immediately notify the Executive Director...."<br><br>This federal tag relates to complaint #IN00169157.<br><br>5-1.2(24)(l) | | | |
| W 0153<br><br>Bldg. 00 | 483.420(d)(2)<br>STAFF TREATMENT OF CLIENTS<br>The facility must ensure that all allegations | | | |

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| | 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.<br>Based on record review and interview for 1 of 18 allegations of abuse, neglect, mistreatment, exploitation and/or injuries of unknown origin reviewed, the facility's management and/or facility staff failed to immediately notify the administrator of an allegation of staff to client abuse involving client A.<br><br>Findings include:<br><br>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 5/20/15 at 9:14 AM. The facility's 3/6/15 reportable incident report indicated "On March 6, 2015 a staff member reported that during a YSIS (You're Safe, I'm Safe-physical restraint technique) on [client A], staff member [staff #1] had made a statement to [client A] that he should have thought about being in a hold before he had behaviors. She then placed three towels over his face, as [client A] was spitting. [Client A] stated that he couldn't breathe, [staff #1] then told [client A] that was too bad and that she would remove the towels when he stopped spitting. Another staff member involved told her to remove the towels | W 0153 | The facility develops and implements written policies and procedures that prohibit mistreatment, neglect and abuse of clients. This includes, but is not limited to immediate reporting of abuse or mistreatment of any client, to the Administrator or other officials in accordance with State Law. The facility trains all employees, upon new hire training on all policies. This includes ResCare's Abuse, Neglect and Exploitation training. This policy states:<br>1.Any ResCare staff person who suspects an individual is the victim of abuse/neglect/exploitation must immediately notify the Program Manager or Quality Assurance Manager, then complete an Incident Report. The Program Manager will immediately notify the Executive Director.<br>All employees will complete ResCare's Prevention of Abuse, Neglect and Exploitation training annually. Quality Assurance staff will review and retrain for employee understanding and competency regarding ResCare's Abuse, Neglect and Exploitation policy. This will include recognizing what constitutes abuse, neglect and exploitation, and the immediate reporting | 07/02/2015 |

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| | and she did. [Staff #1] has been suspended pending investigation...."<br><br>The facility's 3/6/15 Investigative Summary indicated the incident regarding client A occurred on 3/2/15 and was not reported until 3/6/15 by staff #2.<br><br>The facility's 3/6/15 investigation indicated the following (not all inclusive):<br><br>-Staff #2's 3/6/15 Confidential Witness Statement Form indicated "On Monday, 3-2-15, I (staff #2) witnessed a staff member become verbally abusive to a client who was at the current time in a YSIS supine hold. 2nd (second) shift [staff #1] said to the client, when he was asking staff to get off his knee, 'You should have thought of that before.' During the same YSIS, she (staff #1) placed 3 towels over his face and when he told her he couldn't breathe she said 'Too bad. I'll take them off when you're done spitting.' Other staff told her to immediately remove the towels and she did so saying 'Fine. You're the one getting spit on."<br><br>-Staff #3's 3/10/15 witness statement Confidential Witness Statement Form indicated staff #3 assisted in the YSIS hold on 3/2/15. Staff #3's witness | | requirement. This review will occur, at the All Staff Meetings, held each month. Documentation of employee training will be filed and maintained by ResCare Human Resources. Human Resources will submit documentation to the Executive Director quarterly, for verification that all employees maintain policy standards regarding abuse/neglect/exploitation training. ResCare QIDP's will conduct active treatment observations, at least three times per week, one on each shift, to provide support and training, as necessary, on the spot, for thirty days. If sufficient evidence exists that policy and procedure is understood and being followed, after thirty days, and ongoing, ResCare QIDP's will conduct active treatment observations weekly. These observations will be recorded on the active treatment observation form, and submitted to the Executive Director for review and plan of correction, if necessary. Ongoing, ResCare Quality Assurance staff will provide additional support and opportunity for training by conducting at least one weekly active treatment observation. During the course of each month Quality Assurance staff will ensure that there has been at least one observation on each shift. These observations will be recorded on the active treatment observation form. and | |

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| | statement indicated "...While on the floor, [client A] was spitting on the staff holding him. We asked that a towel be placed over [client A's] face to stop him from spitting. During this [staff #1] made remarks that were inappropriate to [client A]. [Client A] said he could not breath (sic), and [staff #1] said So, towel not coming off. I (staff #3) do not remember other comments: [staff #1] was pulled aside by RM (Resident manager) [RM #1] about these comments...."<br><br>-Staff #4's 3/9/15 Witness Statement Form indicated client A had been put in a YSIS standing and supine hold. Staff #4's witness statement indicated client A "...continued to kick and spit. The staff put some towels up as a shield to block the spit from hitting them. At one point [staff #1] put a towel over [client A's] face. He stated he could not breathe. [Staff #2] asked [staff #1] to remove the towel and she said 'He will just spit on us.' Again [client A] asked [staff #1] to remove the towel and she said 'Are you going to stop spitting?' [Client A] replied 'No!' [Staff #1] then said 'Well you should have thought about that before you started spitting.' [RM #1] looked at [staff #1] and said '[Staff #1] you can't say things like that.' At that point a staff member removed the towel from [client A's] face...." | | submitted to the Executive Director for review and plan of correction if necessary. Per ResCare policy, when an allegation of abuse, neglect or exploitation occurs, immediate measures will be taken to protect all clients. ResCare administration and quality assurance staff will complete a thorough investigation and and the appropriate level of corrective action will be taken. The Executive Director will ensure that all investigations are complete, thorough and timely, in order to facilitate any necessary corrective action. Persons responsible: Executive Director, Program Manager, QIDP, Quality Assurance staff Date of completion: 7/2/15 | |

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|---|---|---|---|---|
| | -RM #1's 3/9/15 Confidential Witness Statement Form indicated RM #1 worked the day of the incident. RM #1's witness statement indicated client A was spitting at staff while he was being restrained. RM #1's witness statement indicated RM #1 retrieved a dish towel from the kitchen and "...held in mid air between [client A's] face and [staff #5's] head and face so that [client A's] saliva could not reach [staff #5]. [Client A's] (R) (right) arm was bent at the elbow as with his (R) hand. [Client A] was pulling (the dish towel I was holding) down so that he could spit at [staff #5]. [Client A] was angry that I was holding the towel blocking his spitting as he spit straight upward into my face. At this time, [staff #1] squatted down between myself and [staff #5] and I asked [staff #1] to secure [client A's] right hand so that he could not pull down the towel to spit at [staff #5] or her face. [Client A] seemed to stop spitting as I returned to the kitchen to get more towels to wipe the saliva from [client A's] face and for any staff who had [client A's] saliva on their face...." The witness statement indicated the nurse was getting ready to give the client an injection when she returned. RM #1's witness statement did not indicate anything about a towel being placed on client A's face, but did indicate | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 15G811 | A. BUILDING 00<br>B. WING | 06/02/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RES-CARE INC | 1306 S BLOOMINGTON STREET<br>GREENCASTLE, IN 46135 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | RM #1's witnessing staff #1 making inappropriate statements in regard to client A when he indicated he did not want a shot as it would make his arm sore. RM #1's 3/9/15 witness statement indicated staff #1 told client A "You should have thought of that sooner...." RM #1's statement indicated she spoke with staff #1 and told staff #1 her statement was "inappropriate and uncalled for." RM #1's witness statement indicated she did a verbal counseling with staff #1.<br><br>-RM #2's 3/11/15 witness statement indicated "I (RM #2) did not hear about the incident that happened on 3/2/15 until Wednesday 3/4/15 or early Thursday 3/5/15 from [staff #2] via phone @ (at) that point I advised [staff #2] she needed to tell administration as soon as possible."<br><br>The facility's investigation indicated "...Factual Findings: On the evening of March 2, 2015, [client A] was having a heightened anxiety and was having behaviors for most of the evening. He was attempting to strike the nurse and when staff attempted to verbally deescalate [client A], he began spitting on and attempting to strike staff. He was placed in an HRC (Human Rights Committee) approved YSIS as per his | | | |

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| | BSP (Behavior Support Plan). [Client A] continued spitting. [Staff #1] was not part of the initial YSIS but came to assist the staff after [client A] was in supine position. [Staff #1] placed a towel over [client A's] face in an attempt to block him from spitting. [Client A] yelled out that he could not breathe. [Staff #1] told him that he should have thought of that before. She was told by other staff to remove the towel and she did. [Staff #1] was suspended pending investigation and on 3.10.15 tendered her resignation. Resident Managers (RMs), [RM #1] and [RM #2] were given corrective actions as a result of the incident and their failure to report. All staff were required to participate in inservice training regarding reporting policies before working the floor. Conclusion: It is determined that [staff #1] did place a towel over [client A's] face and made a comment to him regarding his actions that was inappropriate. It is further determined that [staff #1] actions were a direct violation of YSIS training and ResCare policy. Allegations of emotional abuse are substantiated."<br><br>Interview with the Clinical Supervisor (CS) on 5/20/15 at 3:15 PM in regard to the 3/2/15 incident, indicated facility staff should not be placing towels over clients' faces. The CS indicated the 3/2/15 | | | |

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|---|---|---|---|---|
| | incident was not reported timely to the administrator on 3/2/15 when the incident occurred.<br><br>This federal tag relates to complaint #IN00169157.<br><br>5-1.3(h)(1) | | | |