STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G811	A. BUILDING 00 B. WING	08/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES-CARE INC	1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
W 0000 Bldg. 00	This visit was for a Post Certification Revisit (PCR) to the pre-determined full recertification and state licensure survey completed on 6/9/2022. This visit was done in conjunction with an investigation of complaint #IN00384682. Dates of Survey: August 1, 2, 3, 4, 5, 8, and 9, 2022. Facility Number: 013405 Provider Number: 15G811 AIMS Number: 201267570 These deficiencies also reflect state findings in accordance with 410 IAC 16.2-5. Quality Review of this report completed by #15068 on 8/17/22.	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 observation, record review and interview, the facility failed to meet the Condition of Participation: Governing Body for 4 of 4 sampled clients (#1, #2, #3 and #4), plus 16 additional clients (#6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, and #21). The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the agency implemented its written policy and procedures to prevent, report, thoroughly investigate and develop and implement effective corrective measures to	W 0102	**CORRECTION:** *The facility must ensure that specific governing body and management requirements are met.* Specifically: Failed to prevent, report, thoroughly investigate and develop effective measure to prevent recurrence of client #18 alleged sexual assault and inappropriate sexual behavior regarding client #5.	08/29/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	prevent recurrence of client #18's alleged sexual assault and inappropriate sexual behaviors regarding client #5 and to prevent unapproved physical restraints and verbal abuse by staff of client #13, to ensure clients #3, #9, #13, #20's active treatment programs were implemented during formal and informal training opportunities, to ensure the facility's nursing services ensured clients #1 and #2 had High Risk Plans to address their choking and to ensure client #11's High Risk Plan for falls was updated to include a half bed rail as prescribed by a doctor and physical therapy home exercises and to prevent clients #3 and #4 from eating food from the floor, to prevent clients #3 and #17 from taking food from their peers, to promote hand hygiene for client #3, and to ensure dining surfaces were sanitized for clients #1, #2, #3, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, and #21's evening meals. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for 3 additional clients (#5, #13, and #18). Findings include: 1. For 4 of 4 sampled clients (#1, #2, #3 and #4), plus 16 additional clients (#6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, and #21), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure the agency implemented its written policy and procedures to prevent, report, thoroughly investigate and develop and implement effective corrective measures to prevent recurrence of client #18's alleged sexual assault and inappropriate sexual behaviors regarding client #5 and to prevent unapproved physical restraints and verbal abuse by staff of		Failed to prevent unapproved physical restraints and verbal abuse by staff of client #13 Failed to implement formal and informal training opportunities and to ensure that clients #1 and #2 had high risk plans to address choking and clients #11 high risk plan for falls was updated to include a half bed rail, PT home exercises in high-risk plan and prevent clients #3 and #4 from eating food from floor. Prevent clients #3 and #17 from taking food from their peer and failure to promote hand hygiene for client #3 and to ensure dining surfaces were sanitized. · Client #5 has been removed from facility and continues to receive 24/7 staff support during his transition to Medicaid Waiver services. · Investigators to be retrained to identify additional allegations during the course of an investigation and to ensure that any additional allegations are reported appropriately and accurately. · All staff have been certified in agency approved Your Safe I'm Safe behavioral program and techniques. · Client #13 physician has clarified that he can be placed in an agency approved restraint · Clients #1, #2 High Risk plan have been updated to address choking with all staff	

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	client #13, to ensure clients #3, #9, #13, #20's active treatment programs were implemented during formal and informal training opportunities, to ensure the facility's nursing services ensured clients #1 and #2 had High Risk Plans to address their choking and to ensure client #11's High Risk Plan for falls was updated to include a half bed rail as prescribed by a doctor and physical therapy home exercises and to prevent clients #3 and #4 from eating food from the floor, to prevent clients #3 and #17 from taking food from their peers, to promote hand hygiene for client #3, and to ensure dining surfaces were sanitized for clients #1, #2, #3, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, and #21's evening meals. Please see W104. 2. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for 3 additional clients (#5, #13, and #18). Please see W102. This deficiency was cited on 6/9/22. The facility failed to implement a systemic plan of correction to prevent recurrence.		trained · Client #11 High Risk plan has been updated to include half bed rail and home exercise. The half bed rail is present on Client #11's bed appropriately. · All staff have been trained on observation and monitoring mealtimes to prevent Clients #3 and #4 from eating food from floor and Clients #3 and #17 from taking their peers food. · All staff were trained to promote hand hygiene for all clients and to ensure dining surfaces were sanitized. **PREVENTION:** The Program Manager or 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 skills training to assure staff engineer an aggression free training environment and implement Behavior Support Plans, as written. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Program Managers, Quality Assurance Manager, QIDP, Quality Assurance Coordinator, Nurse Manager and Behavioral Consultant) will conduct twice daily administrative monitoring during varied shifts/times, to assure interaction	

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			with multiple staff, involved in a full range of active treatment scenarios, including weekend observations. After 30 days, administrative monitoring will occur no less than three times 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. Current Operations Team members received training from the Operations Support Specialist to assure a clear understanding of administrative monitoring as defined below. · 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 oversight will	

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			include: · Assuring clients feel safe in their home. · Assuring staff competently describe proactive and reactive behavior support strategies for all clients. · Assuring staff engineer the training environment to prevent the development of aggressive behavior. · Assuring staff respond immediately to escalating situations to prevent physical altercations from ensuing. · Assuring staff effectively implement behavior supports as written. · Assuring clients have a safe, calm eating environment **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Direct Support Staff, Operations Team, Regional Director, Operations Support Specialist. **CORRECTIONS COMPLETED BY:** 08/29/22	
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 observation and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), plus 16 additional clients (#6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, and #21), the governing body failed to exercise general	W 0104	**W 104** **CORRECTION:** *The governing body must exercise general policy, budget, and*	08/29/2022

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	policy, budget and operating direction over the facility to ensure the agency implemented its written policy and procedures to prevent, report, thoroughly investigate and develop and implement effective corrective measures to prevent recurrence of client #18's alleged sexual assault and inappropriate sexual behaviors regarding client #5 and to prevent unapproved physical restraints and verbal abuse by staff of client #13, to ensure clients #3, #9, #13, #20's active treatment programs were implemented during formal and informal training opportunities, to ensure the facility's nursing services ensured clients #1 and #2 had High Risk Plans to address their choking and to ensure client #11's High Risk Plan for falls was updated to include a half bed rail as prescribed by a doctor and physical therapy home exercises and to prevent clients #3 and #4 from eating food from the floor, to prevent clients #3 and #17 from taking food from their peers, to promote hand hygiene for client #3, and to ensure dining surfaces were sanitized for clients #1, #2, #3, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, and #21's evening meals. Findings include: 1. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the agency implemented its written policy and procedures to prevent, report, thoroughly investigate and develop and implement effective corrective measures to prevent recurrence of client #18's alleged sexual assault and inappropriate sexual behaviors regarding client #5 and to prevent unapproved physical restraints and verbal abuse by staff of client #13. Please see W149. 2. The governing body failed to exercise general		*operating direction over the facility.* Specifically: Failed to prevent, report, thoroughly investigate and develop effective measure to prevent recurrence of client #18 alleged sexual assault and inappropriate sexual behavior regarding client #5. Failed to prevent unapproved physical restraints and verbal abuse by staff of client #13 Failed to implement formal and informal training opportunities and to ensure that clients #1 and #2 had high risk plans to address choking and clients #11 high risk plan for falls was updated to include a half bed rail, PT home exercises in high-risk plan and prevent clients #3 and #4 from eating food from floor. Prevent clients #3 and #17 from taking food from their peer and failure to promote hand hygiene for client #3 and to ensure dining surfaces were sanitized. ·Client #5 has been removed from facility and continues to receive 24/7 staff support during his transition to Medicaid Waiver services. ·Investigators to be retrained to identify additional allegations during the course of an investigation and to ensure that any additional allegations are reported appropriately and accurately. ·All staff have been certified in	

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	policy, budget and operating direction over the facility to ensure clients #3, #9, #13, #20's active treatment programs were implemented during formal and informal training opportunities. Please see W249. 3. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility's nursing services ensured clients #1 and #2 had High Risk Plans to address their choking and to ensure client #11's High Risk Plan for falls was updated to include a half bed rail as prescribed by a doctor and physical therapy home exercises. Please see W331. 4. The governing body failed to exercise general policy, budget and operating direction over the facility to prevent clients #3 and #4 from eating food from the floor, to prevent clients #3 and #17 from taking food from their peers, to promote hand hygiene for client #3, and to ensure dining surfaces were sanitized for clients #1, #2, #3, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, and #21's evening meals. Please see W454. This deficiency was cited on 6/9/22. The facility failed to implement a systemic plan of correction to prevent recurrence.		agency approved Your Safe I'm Safe behavioral program and techniques. ·Client #13 physician has clarified that he can be placed in an agency approved restraint ·Clients #1, #2 High Risk plan have been updated to address choking with all staff trained ·Client #11 High Risk plan has been updated to include half bed rail and home exercise. The half bed rail is present on Client #11's bed appropriately. ·All staff have been trained on observation and monitoring mealtimes to prevent Clients #3 and #4 from eating food from floor and Clients #3 and #17 from taking their peers food. ·All staff were trained to promote hand hygiene for all clients and to ensure dining surfaces were sanitized. **PREVENTION:** The Program Manager or 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 skills training to assure staff engineer an aggression free training environment and implement Behavior Support Plans, as written. For the next 30 days, members of the Operations Team (comprised of the Executive	

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			Director, Program Managers, Quality Assurance Manager, QIDP, Quality Assurance Coordinator, Nurse Manager and Behavioral Consultant) will conduct twice daily administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including weekend observations. After 30 days, administrative monitoring will occur no less than three times 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. Current Operations Team members received training from the Operations Support Specialist to assure a clear understanding of administrative monitoring as defined below. · 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	

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			supports at the time of the observation is the top priority. · Review all relevant documentation, providing documented coaching and training as needed Administrative oversight will include: · Assuring clients feel safe in their home. · Assuring staff competently describe proactive and reactive behavior support strategies for all clients. · Assuring staff engineer the training environment to prevent the development of aggressive behavior. · Assuring staff respond immediately to escalating situations to prevent physical altercations from ensuing. · Assuring staff effectively implement behavior supports as written. · Assuring clients have a safe, calm eating environment **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Direct Support Staff, Operations Team, Regional Director, Operations Support Specialist. **CORRECTIONS COMPLETED BY:** 08/29/22	
W 0122	483.420(a) CLIENT PROTECTIONS			

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Bldg. 00	The facility must ensure the rights of all clients. Therefore the facility must Based on observation, record review, and interview for 3 additional clients (#5, #13, and #18), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement its written policies and procedures to prevent, report, thoroughly investigate, and develop and implement effective corrective measures to prevent recurrence of client #18's alleged sexual assault and inappropriate sexual behaviors regarding client #5 and to prevent unapproved physical restraints and verbal abuse by staff of client #13, to report an alleged sexual assault and inappropriate sexual behavior by client #18 against client #5, to thoroughly investigate the alleged sexual assault and alleged inappropriate sexual behavior regarding client #5 by client #18, and to develop and implement effective corrective measures to prevent recurrence of client #18's alleged sexual assault and inappropriate sexual behaviors regarding client #5. Findings include: 1. The facility failed to implement its written policy and procedures to prevent, report, thoroughly investigate and develop and implement effective corrective measures to prevent recurrence of client #18's alleged sexual assault and inappropriate sexual behaviors regarding client #5 and to prevent unapproved physical restraints and verbal abuse by staff of client #13. Please see W149. 2. The facility failed to accurately report to Bureau of Developmental Disabilities Services (BDDS) an alleged sexual assault and inappropriate sexual	W 0122	**W 122** **CORRECTION:** *The facility must ensure that specific client protections requirements are met.* Specifically, the governing body facilitated the following: Failed to prevent, report, thoroughly investigate and develop effective measure to prevent recurrence of client #18 alleged sexual assault and inappropriate sexual behavior regarding client #5. Failed to prevent unapproved physical restraints and verbal abuse by staff of client #13 Failed to implement formal and informal training opportunities and to ensure that clients #1 and #2 had high risk plans to address choking and clients #11 high risk plan for falls was updated to include a half bed rail, PT home exercises in high-risk plan and prevent clients #3 and #4 from eating food from floor. Prevent clients #3 and #17 from taking food from their peer and failure to promote hand hygiene for client #3 and to ensure dining surfaces were sanitized. ·Client #5 has been removed from facility and continues to receive 24/7 staff support during his transition to Medicaid Waiver services.	08/29/2022

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	behavior by client #18 against client #5. Please see W153. 3. The facility failed to thoroughly investigate the alleged sexual assault and alleged inappropriate sexual behavior regarding client #5 by client #18. Please see W154. 4. The facility failed to develop and implement effective corrective measures to prevent recurrence of client #18's alleged sexual assault and inappropriate sexual behaviors regarding client #5. Please see W157. This deficiency was cited on 6/9/22. The facility failed to implement a systemic plan of correction to prevent recurrence.		·Investigators to be retrained to identify additional allegations during the course of an investigation and to ensure that any additional allegations are reported appropriately and accurately. ·All staff have been certified in agency approved Your Safe I'm Safe behavioral program and techniques. ·Client #13 physician has clarified that he can be placed in an agency approved restraint ·Clients #1, #2 High Risk plan have been updated to address choking with all staff trained ·Client #11 High Risk plan has been updated to include half bed rail and home exercise. The half bed rail is present on Client #11's bed appropriately. ·All staff have been trained on observation and monitoring mealtimes to prevent Clients #3 and #4 from eating food from floor and Clients #3 and #17 from taking their peers food. ·All staff were trained to promote hand hygiene for all clients and to ensure dining surfaces were sanitized. **PREVENTION:** The Program Manager or Residential Manager will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist	

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			with and monitor skills training to assure staff engineer an aggression free training environment and implement Behavior Support Plans, as written. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Program Managers, Quality Assurance Manager, QIDP, Quality Assurance Coordinator, Nurse Manager and Behavioral Consultant) will conduct twice daily administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including weekend observations. After 30 days, administrative monitoring will occur no less than three times 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. Current Operations Team members received training from the Operations Support Specialist to assure a clear understanding of administrative monitoring as defined below. · The role of the administrative monitor is not simply to observe & Report. · When opportunities for training are observed, the monitor	

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			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 oversight will include: · Assuring clients feel safe in their home. · Assuring staff competently describe proactive and reactive behavior support strategies for all clients. · Assuring staff engineer the training environment to prevent the development of aggressive behavior. · Assuring staff respond immediately to escalating situations to prevent physical altercations from ensuing. · Assuring staff effectively implement behavior supports as written. · Assuring clients have a safe, calm eating environment **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Direct Support Staff, Operations Team,	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			Regional Director, Operations Support Specialist. **CORRECTIONS COMPLETED BY:** 08/29/22	
W 0125 Bldg. 00	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, record review, and interview for 1 additional client (#21), the facility failed to ensure client #21's rights were not infringed upon after meeting discharge requirements for alternative placement options. Findings include: Observations were conducted at the facility on 8/1/22 from 1:27 pm until 2:34 pm, on 8/2/22 from 7:00 am until 9:00 am, and on 8/3/22 from 10:43 am until 10:52 am. Client #21 was present in the facility throughout the observation periods. On 8/1/22 client #21 was lying in his bed with the lights off from 1:27 pm until 2:34 pm. No staff were observed entering client #21's bedroom or prompting him to participate in activities. On 8/2/22 at 8:27 am, client #21 was pacing through the day room while asking for tea. Client #21 appeared unsteady and swayed from side to side. Client #21 leaned to one side while walking and often stumbled. At 8:30 am, client #21 attempted to take client #7's coffee. Client #7	W 0125	**W 125** **CORRECTION:** *The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.* The interdisciplinary team has informed the Bureau of Developmental Disability Services of the need to locate a residential setting that meets Client 21's developmental and behavioral needs with an appropriately matched peer group. **PREVENTION:** The IDT will meet with Client #21's team along with BDDS to discuss transitions to a residential setting that will meet	08/29/2022

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	15G811	A. BUILDING 00 B. WING	08/09/2022

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	grabbed his coffee from the table and stated, "No, [client #21]." Client #3 was running and jumping through the hallways and day room and bumped into client #21 several times. On 8/3/22, client #21 was lying in his bed with the lights off from 10:43 am until 10:52 am. No staff were observed entering client #21's bedroom or prompting him to participate in activities. Client #21's record was reviewed on 8/3/22 at 2:11 pm. Client #21's Individual Support Plan (ISP) dated 8/11/21 indicated the following: "Individual Profile: .... [Client #21's] [family members] are deceased. He is 1 of 4 siblings. His oldest [family member] is his guardian.... [Client #21] lacks the ability to clearly verbalize his needs and wants. He can express his wants by yelling, 'tea,' 'coffee,' 'coke,' 'snack,' and by grabbing staff to direct them to his desired location/item.... Discharge Criteria: The IDT (Interdisciplinary Team) agrees to review [client #21's] Discharge Criteria on a quarterly basis." An IDT meeting note dated 8/11/21 indicated the following: "Purpose of Meeting: Annual Meeting.... Meeting Minutes: Discussed ISP, goals, etc.... Behavioral Data: Discussed Medical High Risk Plans: Discussed.... Recommendations: (BDDS) Bureau of Developmental Disabilities Services) to send alternative placement info (information)...." An IDT note dated 6/22/22 indicated the following: "Purpose of meeting: Follow up on next step from CRMNF (Comprehensive Rehabilitative Management Needs Facility). Meeting Minutes:		developmental and behavioral needs appropriately. The IDT will assist with educating Client #21's team For the next 30 days, members of the Operations Team will conduct daily administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including weekend observations. After 30 days, administrative monitoring will occur no less than three times 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. Current Operations Team members received training from the Operations Support Specialist to assure a clear understanding of administrative monitoring as defined below. · 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.	

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	... Families (sic) biggest concern is that he is non-verbal and can't communicate abuse or neglect if he moves. Family said they would never agree for [client #21] to move unless it is in a locked facility. Family states they will get a lawyer involved to keep [client #21] here.... Waiting on next step meeting from BDDS." Behavior Clinician (BC) was interviewed on 8/3/22 at 1:07 pm and stated, "We had a meeting with BDDS to talk about thoughts for a Behavior Support Plan (BSP) if [client #21] went to a waiver home. We had the meeting to come up with as many ideas as we could, and to make sure we all agree. [BDDS Coordinator] asked [Program Manager] to look at how far back we've been saying he could be discharged. August 17, 2022 is his annual meeting and our next time to talk to the guardians about it. We haven't talked to the family. We've been working with BDDS to come up with things waiver could to to keep him safe." This deficiency was cited on 6/9/22. The facility failed to implement a systemic plan of correction to prevent recurrence. 5-1.2(6)		· 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 oversight will include assuring that clients are placed in a socially and developmentally appropriate environment. The team has scheduled and documented several IDT's held with BDDS and the individual's guardians. At this point the guardians are refusing to consider or allow change of placement for this individual as they feel this is the least restrictive environment for him. The facility continues to meet with BDDS and guardians to facilitate eventual change of placement. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Direct Support Staff, Operations Team, Regional Director, Operations Support Specialist **CORRECTIONS COMPLETED BY:** 08/29/22	
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement			

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	written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 3 additional clients (#5, #13 and #18), the facility failed to implement its written policy and procedures to prevent, report, thoroughly investigate and develop and implement effective corrective measures to prevent recurrence of client #18's alleged sexual assault and inappropriate sexual behaviors regarding client #5 and to prevent unapproved physical restraints and verbal abuse by staff of client #13. Findings include: 1. DSP (Direct Support Professional) #4 was interviewed on 8/1/22 at 4:16 PM. DSP #4 stated on Saturday, July 23, 2022, "I was in the dayroom working on paperwork while waiting for lunch to be served. I watched [client #18] smack [client #5] on his butt. I redirected [client #18]. They were standing by the tables when it happened." DSP #4 stated, "After redirecting, I noticed [client #18] walked around behind me where I was sitting and then I saw [client #5] go behind me. I turned around and saw [client #18] groping [client #5's] private parts with his left hand behind me. I redirected them and got the RM (Residential Manager), [RM #1] and told her about the situation. [Client #5] didn't want to talk about it." DSP #4 indicated client #5 then went on a visit with his guardian. DSP #4 indicated when client #5 returned from his visit he requested to speak with her. DSP #4 stated client #5 returned from his visit at "approximately 2:40 PM and we went on the front porch with just him and I (sic). We started discussing the incident prior to his visit. I educated him on sexual inappropriate behavior and told him he should report it to staff. He told	W 0149	**W 149** **CORRECTION:** *The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.* Specific corrections include: ·Client #5 has been removed from facility and continues to receive 24/7 staff support during his transition to Medicaid Waiver services. ·Investigators to be retrained to identify additional allegations during the course of an investigation and to ensure that any additional allegations are reported appropriately, accurately and reported timely. ·Investigators to be retrained to complete investigations within 5 business of alleged incidents ·Investigators to be retrained on including recommendations to the investigation summary to prevent recurrence. ·Investigators to be retrained on interviewing all witnesses and potential witnesses · All facility investigations will be completed by trained investigators. When incidents requiring investigation occur, the QA manager or designee will assign the investigation to a	08/29/2022

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	me it had happened before but didn't have an exact date. We tried to pinpoint a time but it had happened multiple times over the last few years. He said he had told staff before and [client #18] told him to keep his mouth shut." DSP stated client #5 reported "[Client #18] had come in his and [client #12's] bedroom and that [client #18] had pulled out his private and forced [client #5] to suck on it. [Client #5] was telling him no multiple times. [Client #18] had attempted it with [client #12] and he told him no. [Client #12] was left alone. [Client #12] was present in the bedroom when it happened. [Client #5] told me he was in the pacer's hall shower before 8 AM. [Client #18] entered the shower. [Client #18] had intercourse with him again and he told him no." DSP #4 stated client #5 reported "[Client #18] entered the shower and he told [client #18] no. Said that he tried to move away but was backed into a corner." DSP #4 indicated client #5 reported the day of the shower incident was 7/23/22. DSP #4 indicated the day of the bedroom incident was not able to be determined but was in July 2022. DSP #4 indicated she immediately reported the allegations to RM #1. DSP #4 indicated client #5 was taken to the hospital for a sexual assault examination. DSP #4 indicated client #5 was moved to another area of the building away from contact with client #18 and then was moved to a waiver home. DSP #4 indicated client #5 came to the agency campus during the day and did not have further contact with client #18. DSP #4 stated client #5 had "never lied to me in the time that I've known him. Other staff report he's a liar but I feel like he was being honest. He had been depressed." DSP #4 indicated client #18 did not have special supervision or monitoring prior to the 7/23/22 incident. DSP #4 stated, "Personally, I would never have him around another peer. [Client #18]		specific investigator. The QA manager or designee will conduct follow-up with the investigator to assure completion within required timeframes. ·All staff have been certified in agency approved Your Safe I'm Safe behavioral program and techniques. **PREVENTION:** For the next 30 days, members of the Operations Team will conduct daily administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including weekend observations. After 30 days, administrative monitoring will occur no less than three times 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. Current Operations Team members received training from the Operations Support Specialist to assure a clear understanding of administrative monitoring as defined below. · The role of the administrative monitor is not simply to observe & Report. · When opportunities for training are observed, the monitor	

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	likes to make allegations. Any clients that can't talk. Any that are non-verbal like [client #10], [client #11], [client #19], [client #9]. Any that can be peer pressured. I wasn't present but it was reported [client #18] made a threat to rape [client #14] that night." DSP #4 indicated client #18's bedroom bathroom door was now locked and he was not allowed alone with any peers, and was in line of sight when he was outside of his bedroom. An additional IR (Incident Report) dated 7/23/22 was reviewed on 8/4/22 at 5:01 PM. The review indicated the following: -"On the above date and time (7/23/22 at 3 PM), [client #5] came to staff to report that he's been sexually assaulted. Staff began to take note of [client #5's] report. [Client #5] stated that over the course of the last 1.5 - 2 years [client #18] had been sexually assaulting him. [Client #5] stated that within the last 1-2 weeks while in his bedroom that between 8 PM and midnight while staff is switching over that [client #18] comes into his bedroom unnoticed, then [client #18] tells [client #12] to leave the room and [client #18] proceeds to give [client #5] a [masturbating] has oral sex with [client #5] to wake him up then [client #18] places his penis inside [client #5] and sodomize [client #5] (sic). [Client #5] stated it happens frequently and the most recent incident took place [client #5] stated was 7/23/22 while [client #5] was in the shower in pacer's hallway (sic). [Client #5] stated that [client #18] entered the shower room and at that time [client #18] began to sodomize [client #5]. [Client #5] went on to state to staff that [client #18] told him and [client #12] both that if anyone found out that [client #18] would kill them both. [Client #5] stated he was scared to tell anyone after being threatened and a former staff that he did tell didn't do anything to protect [client		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 oversight will include assuring that clients are placed in a socially and developmentally appropriate environment. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Direct Support Staff, Operations Team, Regional Director, Operations Support Specialist **CORRECTIONS COMPLETED BY:** 08/29/22	

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	#5]. [Client #5] stated while he was visiting with his parents on 7/23/22 he was going to tell his parents but got scared. But then came to report to staff. [Client #5] stated his roommate [client #12] was fully aware of [client #18] having oral sex and sodomizing [client #5] due to [client #18] making [client #12] leave the room while the assaults take place in [client #5's] bed. [Client #12] was also questioned by staff and [client #12] gave staff the same information that [client #5] had. At just shortly after 4 PM, after speaking to program manager, [client #5] was taken to [first emergency room] to be examined. [First emergency room] then sent [client #5] to [second hospital] to be examined by sex assault doctor. At 5:30 PM, [client #5] left [first hospital] and arrived at [second hospital] at 6:15 PM. [Police] was (sic) notified before transport and [client #5] and [RM #1] gave police statements and they will do follow up investigation upon results of assault testing. Further information will follow upon discharge from hospital." The facility's BDDS (Bureau of Developmental Disabilities Services) reports and Investigations reviewed on 8/1/22 at 2:10 PM. The review indicated the following: -"Describe the injury, condition or circumstance of the incident and the activities taking place immediately prior to the incident. Identify all participants and their involvement in the incident. Please be comprehensive but concise in explaining who, when, where, why, how and what was heard and/or observed." -BDDS report dated 7/24/22 indicated, "On July 23, 2022, at 3 PM, [client #5] reported to staff that he allegedly had been sexually assaulted by [client #18]. [Client #5] was transported to [first			

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	Emergency Room] for an examination then transferred to [second Emergency Room] due to not having a sex assault examiner on shift. While at [first Emergency Room] [client #5] and staff both gave statements to the [police] and a police report was filed. The forensic rape examination was performed and [client #5] was released from the hospital. And, [Client #5] has been offered emotional support. [Client #5] with team/guardian approval has been moved to a different building. [Client #5] and [client #18] will remain separated until further notice. [Client #5] will receive one on one staff supports while staying in alternative building. [Client #18] will receive 5-minute checks while in his bedroom and line of sight when out of his bedroom. [Client #18] does not have a roommate. Both individuals are scheduled to meet with the detective separately on 07/25/22 to provide further statements. ResCare will cooperate with the [police department's] investigation. ResCare has also initiated an investigation. The administration team including Executive Director were notified. IDT (Interdisciplinary Team) meeting to be held for both individuals to discuss further protective and preventative measures." The 7/24/22 BDDS report did not indicate documentation of reporting the circumstance of the incident and the activities taking place immediately prior to the allegations. The 7/24/22 BDDS report did not indicate documentation of identifying all participants and their involvement in the incident. The 7/24/22 BDDS report did not indicate documentation of explaining who, when, where, why, how and what was heard and/or observed. Client #5's allegations as reported and			

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	known by the facility on the 7/23/22 at 3 PM Incident report were not reported to BDDS. The facility provided an Investigation Summary dated 7/29/22 with the word 'Draft' written on it. The Investigation Summary dated 7/29/22 did not include documentation of a conclusion or recommendations. The 7/29/22 Investigation Summary did not indicate documentation of an addendum or extension. The facility did not complete an investigation within 5 business days of the alleged incident (7/23/22). ED (Executive Director) via email on 8/2/22 at 10:53 stated, "Good morning, we will have the complete investigation and reviewed this afternoon at 3 PM. We had an extension to the addendum due to the scope of the investigation." An additional investigation summary was received via email on 8/2/22 at 2:54 PM. The Investigation Summary dated 7/29/22 signed on 8/2/22 indicated the following: -"Introduction On July 23rd, 2022, at 3 PM, [client #5] reported to staff that he allegedly had been sexually assaulted by [client #18]. [Client #5] was transported to [first emergency room] for an examination then transferred to [second emergency room due to not having a sex (sic) assault examiner on shift. While at [first hospital] [client #5] and staff both gave statements to the [police] and a police report was filed. The forensic examination was performed and [client #5] was released from the hospital." -"Scope of Investigation 1. Did Individual [client #18] sexually assault			

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	Individual [client #5]? 2. Has Individual [client #18] touched [client #5] in an unwanted, inappropriate manner? 3. Did Individual [client #5] consent to sexual acts with Individual [client #18]? 4. Was Individual [client #18's] supervision level followed appropriately by staff? 5. Was Individual [client #5's] supervision level followed appropriately by staff? 6. Did staff fail to follow ResCare Policy and Procedures?" -"Investigative Procedure Physical/Demonstrative Evidence Documentary Reviews 1. Rest Assured Camera System-July 22 at Midnight until July 23 at 4 PM. 2. Staff Assignment Sheets- Staff assigned to staff for GOALS July 22 and July 23. 3. Progress Notes for Individual [client #5] dated July 23, 2022. 4. Progress Notes for Individual [client #18] dated July 23, 2022. 5. 5-minute Checks July 22 and July 23, 2022 6. Hospital Discharge Records for Individual [client #5] dated July 23, 2022. 7. Review Cell Phone Photo." -"[RM #3] On July 25th, 2022, [RM #3] stated that she is not aware of any inappropriate touching in anyway with any consumers. [RM #3] stated that [client #18] does enter everyone's rooms and get redirected to come back out. [RM #3] has never seen any clients doubled (sic) and or in the restrooms together at any time she has worked. [RM #3] stated that on July 21st, 2022, she witnessed [client #18] walking [client #1] in from a fire drill holding his hand to help him in the building and when she noticed she redirected him			

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	and asked what he was doing he stated I was putting him in his room he was scared (sic)." RM #3's witness statement form signed and dated on 7/25/22 indicated, "Stated on July 21st, 2022, I witnessed [client #18] walking [client #1] to his bedroom holding his hand. [RM #3] asked him what he was doing, [client #18] stated he was a tucking him into bed. She stated its late you shouldn't be in his room, I will tuck him into bed and [client #18] went to his room and shut his door (sic)." The Investigation Summary of RM #3's statement did not include details of client #18's actions inside of client #1's bedroom or client #18's stated intentions of tucking client #1 into his bed. -"On 7/28/22, [DSP #11] stated that he witnesses [client #18] horseplay all the time with clients but never inappropriate manner at all. [DSP #11] stated that he sees [client #18] enter clients' rooms and he will redirect him to get out. [DSP #11] stated that [client #18] could of went (sic) into someone's room for like 10 to 15 minutes a long time ago but doesn't remember the room. [DSP #11] stated that he has seen [client #18] enter [clients #5 and #12's] room but just stands at the doorway. [DSP #11] stated he has never seen any clients touching inappropriately at all." DSP #11's Witness Statement form was signed and dated 7/28/22 and indicated, "Does [client #18] go in everyone's rooms? Yes, could be in there for 10-15 minutes. What does he do? He talks to them." DSP #11's Witness form indicated, "Do you ever see him go into [client #5's] room? Yes, a few times. He is talking to [clients #5 and #12]." DSP #11's Witness form indicated, "Do clients have relationships? He stated awhile back			

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	that both [client #18] and [client #5] were dating." DSP #11's Witness statement and Investigation Summary were not consistent in the description of client #18's time of 10-15 minutes of being in clients #5 and #12's bedroom. The statement does not indicate documentation of a timeframe as described in the investigation summary. RM #3's investigation summary did not include details of client #18's actions inside of client #1's bedroom or client #18's stated intentions of tucking client #1 into his bed. -"On 7/23/22, [DSP #4] witnessed [client #18] at 12:06 PM smack [client #5] on his bottom, (sic) I educated [client #18] on sexual inappropriate behavior and personal space. [Client #18] then walked behind me and hugged [client #5]. I turned around to look behind me and witnessed [client #18] rubbing [client #5's] private area with his left hand. At this time, I educated [client #18] again on sexual inappropriate behavior and personal space. I then spoke with [client #5] and he told me he would like to speak to me after his visit with his mom and dad 12:50 PM. I reported to the RM, filled out the proper paperwork and went on about my day fulfilling my duties as a DSP. Once [client #5] returned from his visit at 2:20 PM, he had a snack and asked me to take him out on the front porch so we could speak in private. I told the RM what I was doing and I took [client #5] to the front porch. [Client #5] began talking about the incident that took place prior to his visit. [Client #5] informed me that [client #18] had raped him. I immediately reported these allegations to [RM #1] - the RM on duty. [RM #1] then contacted [PM (Program Manager)] to inform her of the situation. Then I had [client #5] write everything down. I followed the RM instructions.			

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	[DSP #4] took notes on 7/23 of [client #5] on the front porch bullet points -[Client #5] allegedly accusing [client #18] of rape more than once. -[Client #5] claims [client #18] has touched him inappropriately. -[Client #5] claims he has told [client #18] no each time. -[Client #5] claims [client #12] witnessed alleged accusations. -[Client #5] claims (the) most recent was in Pacer's shower room on third shift while [client #5] was showering. -[Client #5] claims he told [DSP #17] about the situation prior to him (sic/unknown) but [DSP #17] isn't here anymore. -[Client #5] claims he does not feel safe. -[Client #5] claims [client #18] threatened to kill both him and [client #12] if they told anyone. [DSP #4] took notes on 7/23 of [client #12] on the front porch bullet points -[client #12] claims the last 2 nights (7/22 and 7/23) [client #18] has come into his room after snack time and pulls his private parts out and makes [client #5] suck his private parts. -[client #12] claims [client #18] has had intercourse with [client #5] while [client #5] said no. -[client #12] claims [client #18] has humped him and asked for sex and [client #12] has refused. -[client #12] claims [client #18] say (sic) not to tell anyone or he will kill both of [client #12] and [client #5]. [DSP #11] when interview (sic) on 7/25/22, [DSP #11] (sic) stated she heard [client #5] talking with his mom on 7/23/22 around 2130 at night and [client #5 (sic)] mom asked him why he didn't tell			

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	her and [client #5] felt that he was being blamed." -"On 7/23/22 about 3 PM, my staff [DSP #11] came to me, [RM #1], and advised me about a sexual assault that not only had taken place on the date mentioned above (7/23/22) but also throughout the year and half. I then spoke to [client #5] and his roommate [client #12]. [Client #5] stated that [client #18] would sneak past staff at busy time in the evenings and go into [clients #5 and #12 (sic)] room. [Client #18] would then attempt to have a sexual encounter with [client #12] and when [client #12] would tell him no [client #18] would then move over to [client #5 (sic)] bed where he would force [client #5] for oral sex on [client #5] then [client #18] would force anal sex on [client #5]. [Client #12] stated to [RM #1] when interviewed separately from [client #5] the exact same story. I then called the [PM] to let her know of the situation." -"[RM #1] stated that [client #12] has come to staff I believe on the 2nd shift and stated that [client #18] sent me nude photos. [RM #1] states that [client #18] has sent [client #12] text that state 'I will suck your [penis]' (this has been recently written up). [RM #1] states that on 7/23/22 [client #12] received a picture of his [penis] to (sic) his phone. [RM #1] stated that on 7/23/22 that once [clients #5 and #12] spoke to me [client #5] went and barricaded himself in his room. [RM #1] states that [client #5] took apart his fan for protection against [client #18]." -"[RM #1] states that she heard several months when [DSP #17]was here that [client #12] was so tired of getting messages from [client #18] (sic)."			

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	RM #1's Witness statement form signed and dated 7/25/22 indicated, "I have watched [client #18] on second shift attempt to enter into [clients #5 and #12's] room when [client #18] would apparently think staff was not watching. I have prompted [client #18] multiple times to stay of out of peers rooms and there are no other instances to my knowledge. [Client #5] has also previously stated he didn't feel safe at the facility when I spoke to [client #5] he would never tell me exactly why due to being scared of being seriously injured by [client #18] as [client #5] stated to us, 'I know what he did to my staff when he stabbed them (sic).'" The review did not indicate documentation of RM #1's statements regarding client #18's attempts to enter clients #5 and #12's bedroom and statements of feeling unsafe due to client #18's physical aggression towards former staff. -"On 7/28/22 [AD (Activity Director)] stated she has never seen [client #18] enter other clients' rooms but she stated he likes to stand at the doorways of them and talks with other consumers. [AD] stated that she has never seen [client #18] enter [client #5's] room at any point. [AD] stated that she has witnessed them hugging in the dayroom before dinner and she stated that she would redirect them. [AD] made a statement that she has heard over the course of a year that [clients #5 and #18] have been dating but never seen (sic) anything between them." -"On 7/28/22 [DSP #16] stated that over her few months work with ResCare never seen (sic) [client #18] enter [client #5] or [client #12] room She stated that she sees [client #3] enter everyone's room as he just runs in and runs right back out. [DSP #16] stated that she has seen [client #18]			

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	come out of consumers room (sic) she stated only on Sunday when he was asking where [client #5] was. [DSP #16]stated she is not aware of anyone having any relationships and or any inappropriate touching." DSP #16's Witness statement form was signed and dated on 7/28/22. DSP #16's witness statement form indicated, "Have you ever seen [client #18] go in rooms? No, but I see (sic) him come out. Have you ever seen [client #18] in [client #5] (sic) room? Yes, on Sunday he said he was looking for him." DSP #16's investigation summary and witness statement were not consistent in documentation regarding client #18's coming out of client bedrooms. -"On 7/28/22, [DSP #2] stated that he has never witnessed any inappropriate touching other than a hug at dinner time on occasion. [DSP #2] stated that he has seen [client #18] enter [clients #5 and #12] (sic) room all the time and when I see him go in, I redirect and he comes right back out. [DSP #2] stated that [client #18] asks all the time how [clients #12 and #5] are if they are not in the building and when they will be back." DSP #2's witness statement form signed and dated 7/28/22 indicated, "Have you ever witnessed [client #18] or [client #5] touch? No, they do give hugs at dinner but that's all. When they hug its for a long period of time I have seen [client #18] enter [clients #5 and #12] (sic) room almost every time I work, When I see him I redirect he doesn't go all the way in (sic). He always wants to know is going on with [clients #5 and #12]." DSP #2's witness statement form dated 7/28/22 indicated the statement was documented by ED via			

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	telephone call. The witness form had a written statement by DSP #2 on the back of the page. The written statement indicated, "I have been seeing [client #18] go into [clients #5 and #12's] room to see what's going on in there. I had asked [client #18] what he needed and he states he's just checking something. [Client #18] does it one or so (sic) everyday I work." DSP #2's investigation summary, witness statement and written witness statement forms were not consistent in documentation of DSP #2's testimony. -"On 7/25/22, [client #5] states that he told staff that [client #18] was being sexual with him. [Client #5] stated that [client #18] was sending pictures and stuff to my phone. [Client #5] stated to staff that he didn't feel safe anymore. [Client #5] states that it was around 2 AM, [client #18] came into my room and got on top of me and whipped out his [penis] and started to masturbate on me. [Client #5] (stated he) then put his penis inside me for about 20 minutes. [Client #5] stated he has told [client #18] no before." -"On 7/25/22, [client #12] stated on Saturday the (7/23/22), [client #12] stated (sic) afternoon at about lunch time [client #18] came into [client #5] and I room (sic) and he jumped on [client #5] and told him to pull his pants down. [Client #18] was in our room for about 30 minutes. [Client #12] states that he was back and forth between being awake and sleep, (sic) [client #12] states that when [client #18] realized I was waking up he jumped up and ran out of the room. [Client #12] states that [client #5] kept yelling 'No' but [client #18] doesn't listen to anybody. [Client #18] states nothing happened during the overnight hours leading up to Saturday afternoon.			

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	On 7/28/22, [client #12] stated that [client #18] came into our room and I was half asleep and [client #18] came into our room and I was half asleep and [client #18] told [client #5] to pull his pants down and [client #18] sucked [client #5] penis. States that [client #18] wouldn't get off him. It has never happened before. [Client #12] states last time he saw it was a couple of weeks ago. [Client #18] ran into our door and wouldn't let [client #5] out, he wanted to talk to him and [client #18] were having sex and [client #5] stated to get off me when I walked in (sic). [Client #12] states that he has never seen them in the shower together. [Client #12] states one time he came into his room and [client #5] and [client #18] were having sex and [client #5] stated to get off me when I walked in. [Client #12] states that [client #18] has sent him pictures on his phone and I have attempted to delete them and I can't figure it out. [Client #12] showed [ED] the pictures on his phone. [Client #12] stated that he has heard that [clients #18 and #5] are dating but [client #5] tells me they are not. [Client #12] states sometimes I have run into my bathroom when [client #18] comes in our room and sit on the floor because I was scared. I would hear [client #18] and [client #5] doing things but I have never distracted staff so they could do things." -"On 7/28/22 [client #18] states he doesn't go into anyone's room, I like to stand at the doorways. [Client #18] states that he doesn't touch anyone inappropriately other than [client #5]. [Client #18] states that [client #5] lets me [masturbate him] and [oral sex]. [Client #18] states that we have been together along time before ResCare. [Client #18] states that [client #12] distracts staff so me and [client #5] can [masturbates] each other. [Client #18] states that [client #5] [masturbates] and I			

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	sometimes [perform oral sex] because he is my boyfriend. [Client #18] states last time we did it was [client #18] thinks it was Thursday or Friday. [Client #18] states that 3 or 4 months ago I was in the shower and [client #5] came and told me to [perform oral sex]. [Client #18] states he did it while he was on the shower chair. [Client #18] states on Saturday [client #12] was mad cause I wouldn't [masturbate] him off. [Client #18] told [client #12] I couldn't do that I am with [client #5]. [Client #18] states I am bi-sexual. [Client #18] states [client #12] has sent him videos of girls with big [vagina with explicit description]. [Client #18] stated that sometime [client #12] will stay and watch and he [masturbates] while we are doing stuff." -"[Client #8] states that he has seen [client #18] and [client #7] in the shower before with the door open, they had their clothes on. I have never seen anything else between anyone ion (sic) the building." -"On 7/28/22, [client #14] states that he didn't see anyone go into [clients #12 and #5] room on Saturday 7/23/22. [Client #14] states that in the kitchen a long time ago that [client #18] grabbed his [testicles]. [Client #14] stated [client #18] said if you don't let me touch you then there will be consequences. [Client #14] states he has never done anything since that day but doesn't remember the day on our hallway (colts) but he says [client #18] will go into other client's room on the other hallway (pacer's). [Client #14] states he has never seen [client #18] or [client #5] touch each other at all." -"On 7/28/22, [client #7] states that no one has ever entered his room since he has changed rooms. [Client #7] stated over a year or more that			

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	[client #18] touched his penis but that was investigated and nothing has happened since that day. [Client #7] stated he has seen [client #18] enter [client #5] room a few times but he just talks to them and staff get him out when they notice. [Client #7] states that he has never seen [client #18] or any clients dating each other at all." -"On 7/28/22, [client #15] states he has seen [client #18] enter [client #5] room several times and he says he went into his room at 6:30 PM on Saturday night. [Client #15] states I think he wanted to know if [client #5] was ok cause he wasn't in the building. [Client #15] states he has seen [client #18] touch other clients. [Client #15] states he likes to horseplay with everyone. [Client #15] stated that he sees [client #14] and [client #18] in everyone's rooms and they like to talk to everyone. [Client #15] stated nothing happened on Saturday the 23rd that he remembers." -"Factual Findings 1. [Client #14] states [client #18] has made threats related to sexually acts one time to him. 2. [Client #16] states the [client #18] enters [client #5] room for approximately 60 seconds and others room but nothing has happened. 3. [Client #19] states that [client #18] was seen entering [client #5] room for 2 seconds. 4. [Client #5] first interview (7/25/22) he stated [client #18] sent pictures to his phone, [client #18] masturbated on him, [client #18] had his penis inside of him for 20 minutes and he does not feel safe. 5. [Client #5] second interview (7/28/22) he stated he has never had sex with [client #18], [client #18] performed oral sex on him but they have never had sex. 6. [Client #12] states that while in the room, [client #18] jumped on [client #5] (who) kept yelling no.			

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	7. [Client #18] denies going into anyone's room, he does not touch anyone inappropriately other than [client #5]. [Client #18] stated that he and [client #5] are 'together' and [client #12] distracts staff so that they can [masturbate] each other off. 8. [AD] has heard [clients #5 and #18] are 'together' but has not seen anything occur between them. 9. [DSP #16] has never observed [client #18] enter [client #5] or [client #12] rooms and she is not aware of anyone being in a relationship. 10. [DSP #2] has not observed inappropriate touching and that he does see [client #18] enter [clients #5 and #12] room all the time but he comes right back out. 11. [RM #3] has not observed inappropriate touching and [client #18] enters everyone's bedroom but redirected to exit. 12. [RM #5] has not seen anyone going into other bedrooms at night and has not observed touching other individuals. [RM #5] heard a long time ago that [clients #18 and #5] are together as boyfriends. 13. [DSP #11] has not witnessed inappropriate touching. 14. [RM #2] states that he has not witnessed inappropriate touching. 15. [RM #4] states they position themselves in the hallway so there was no way something could have happened on third shift and she heard 4 months ago that [client #18] and [client #5] were dating. 16. [DSP #4] witnessed [client #18] smack [client #5] on his bottom, hug [client #5] and rub [client #5] private area. 17. [RM #1] stated [client #5] reported that [client #18] forced oral sex and anal sex with him and [client #12] reported the same. 18. Nude photos and sexually suggestive text messages were sent from [client #18] to [client			

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	#12] and [client #5]. 19. [Client #18] did not receive enhanced supervision at the time the alleged incident occurred. 20. [Client #5] did not receive enhanced supervision at the time the alleged incident occurred. 21. Camera footage on 7/23/22 revealed the following: -Footage shows at 12:06 PM shows [client #18] touching [client #5] in unwanted touch. -[Client #18] based off the camera footage does not go into [client #5] and [client #12] room upon [client #5] return from meeting with his guardians. -Based off camera [client #18] does go to [client #5] and [client #12] room but does not go into the room, opens the door and shuts. 22. Per [police department detective] this investigation is ongoing. 23. The results of the [client #5] rape forensic examination have not yet been received. 24. Both clients have legal guardians. 25. According BSP [client #12] has target behaviors for telling stories that he will sometimes later recant. He is quick to do this if he feels that it will help him avoid getting into trouble. 26. According to BSP [client #5] has target behaviors for inappropriate sexual behaviors: defined as exposing his genitals to others in public places, touching other's private areas, rubbing himself on others, or making verbalization/gestures of a sexual nature to other in a common area. Also included masturbating in public areas. Includes attempt to remove the clothing of others. False reports/calls to 911: defined as any time he calls 911 and hangs up or any time that he calls 911 to make a false report. 27. According to BSP [client #18] has target behaviors for false reports/making hang up ca lls with 911: defined as any time he calls 911			

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	and hangs up or any time that he calls 911 to make a false report. Boundary violations: defined as hugging others without permission, rubbing the backs/arms/bodies of others or invading the personal space of others. Included acts of flicking or poking others. [client #18] has demonstrated boundary violations against staff and peers."-"Conclusion1. It is not substantiated that [client #18] sexually assaulted [client #5].2. It is substantiated that [client #18] touched [client #18] in an inappropriate manner.3. It is not substantiated that [client #5] did not consent to sexually acts or to be touched by [client #18].4. It is not substantiated that [client #18] supervision level was not followed appropriately by staff.5. It is not substantiated that [client #5] supervision level was not followed appropriately by staff.6. It is not substantiated that staff failed to follow ResCare policy and procedure."The Investigation Summary did not include recommendations to prevent recurrence. PM via email on 8/5/22 at 12:44 PM indicated DSP #3, DSP #6, DSP #7, DSP #9, DSP #12, DSP #13, DSP #14 and DSP #18 worked at the facility on 7/22/22 and/or 7/23/22. The investigation summary did not include interviews with DSP #3, DSP #6, DSP #7, DSP #9, DSP #12, DSP #13, DSP #14 and DSP #18 as potential			

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	witnesses regarding client #5's 7/23/22 allegation of sexual assault by client #18. ED was interviewed on 8/3/22 at 1:18 PM. ED indicated he had completed the Investigation regarding client #5's 7/23/22 allegation of sexual assault. ED indicated the initial allegation was client #18 had raped client #5. ED indicated client #5's recollection of the timeframes of the alleged incident was between 2-3 AM or 12:30 PM on 7/23/22. ED indicated client #5 alleged client #18 entered his room, jumped on him and penetrated his anus while he was telling him no. ED indicated he was not initially aware of the allegation of sexual assault in the shower room. ED indicated the BDDS report included the basics regarding staff notification, date and where client #5 was taken. ED indicated the BDDS report did not include the specific circumstances of the allegations. ED indicated the investigation was completed between 7/25/22 and 7/29/22 with the final investigation summary completed 8/2/22 at 3 PM. ED indicated he made recommendations to have client #18 be placed on 1 to 1 staff to client ratio supervision. ED stated he had made the recommendations based on "what I heard during the investigation that it would be one way to include (sic) the safety of the other clients. He's currently on 5-minute checks because of prior elopement." ED indicated			

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	his recommendations for 1 to 1 staff to client ratio supervision for client #18 had not been implemented. ED indicated he would need to follow-up with PM to begin implementation. ED stated, "I don't believe he's targeting other clients. I heard of lot of hugging or horseplay but could be redirected. (Recommendation) basing it off of past history." ED stated, "He routinely enters other client bedrooms." ED indicated client #18 should not be in other clients bedroom as a part of ResCare's policy. ED indicated client #18's BSP did specify he should not be in bedrooms of his peers. ED indicated he reviewed the agency's video monitoring system from 12 AM through 4 PM on 7/23/22. ED indicated he was not aware of any allegations prior to 7/23/22 at 12 AM. ED indicated client #5 had a guardian and would need guardian consent with the IDT to engage/consent to a sexual relationship/activity. ED indicated there was not IDT or guardian consent. ED indicated the investigation included allegations regarding client #18's use of his phone to send clients #5 and #12 explicit pictures and explicit messages. ED indicated he had recommended restrictions on client #18's personal phone. ED indicated there was not documentation of the cell phone restrictions recommendations included the investigation. ED indicated the investigation included			

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	factual finding #7. ED indicated factual finding #7 documented client #18's admission of touching client #5 due to being in a relationship. ED indicated the investigation included a conclusion #3. ED indicated conclusion finding #3 documented it was not substantiated client #5 did not consent to sexual acts or to be touched by client #18. ED indicated client #5 should not be dating other clients and did not have guardian and IDT support or approval to consent to being in a sexual relationship or acts. ED indicated he based the unsubstantiated on the sexual assault aspect. ED indicated the investigation included an interview with DSP #4. ED indicated DSP #4's interview included allegations for the two nights prior to the 7/23/22 allegations. ED indicated he had reviewed the camera for 7/23/22 12 AM through 4 PM. ED indicated he substantiated the facility followed its policy and procedures. ED indicated the facility's abuse and neglect policy should be implemented, allegations should be reported to BDDS, allegations should be thoroughly investigated within 5 business days and corrective measures should be developed and implemented to prevent recurrence. QIDP (Qualified Intellectual Disability Professional) was interviewed on 8/3/22 at 11:28 AM.QIDP indicated he had been at the facility in the			

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	QIDP role since 7/22. QIDP indicated his primary role was as a Quality Assurance staff at another agency location. QIDP indicated he was an agency trained investigator. QIDP indicated he was assigned to assist with the investigation of client #5's 7/23/22 sexual assault allegations but was relieved from this role as ED (Executive Director) became the lead assigned investigator. QIDP indicated prior to being reassigned off of the investigation he had begun a review of clients #5 and #18's BSP's, ISP's and daily progress notes. QIDP indicated he had completed an interview with client #5 prior to the ED taking over the investigation. QIDP indicated client #5 alleged the incident happened at 2 AM on 7/23/22. QIDP stated, "[Client #5] said that [client #18] just came in his room and got on top of him. Took his penis out and started masturbating on top of him and had intercourse with him. Told him no and he continued." QIDP stated, "[Client #12] alleged the incident happened at 12:30 PM or lunchtime on the 7/23/22. Basically said [client #18] came in their bedroom and had sex with him. [Client #5] repeatedly said no." QIDP indicated client #5 had a guardian and would need guardian consent to engage in a sexually active relationship or give consent. QIDP indicated the 7/24/22 BDDS report regarding the 7/23/22			

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	allegations did not describe the specific circumstances of the allegations in the narrative. QIDP indicated client #18's BSP included 5-minute checks in his bedroom and line of sight supervision when outside of his bedroom after the 7/23/22 incident. QIDP stated, "I don't see it in his BSP specifically but would imagine with his history he should not be (in other clients bedrooms)." QIDP indicated client #18 had a cell phone. QIDP indicated client #18's BSP did not include monitoring or supervision of client #18's cell phone or Internet usage related to sending his peer's sexually explicit images. QIDP indicated he had not seen or witnessed any incidents of client #18 violation of boundaries or inappropriate touching his peer's. QIDP indicated if client #18 continued to touch his peer's inappropriately with line of sight supervision the intervention should be evaluated for effectiveness. QIDP indicated he was not aware of any allegations or threats from client #18 towards his peer's. QIDP indicated he was not aware of clients reporting being fearful or intimidated by client #18. QIDP stated, "I know there are some that steer clear of him not seen any shy away or run." QIDP indicated clients #3 and #4 didn't go around client #18. RM (Residential Manager) #1 was interviewed on 8/1/22 at 5:17 PM. RM #1 indicated her			

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	role included ensuring staff implemented BSP's and ISP goals. RM #1 stated, "[Client #18] has massive behaviors. Around the end of January, he acted out. I'm not sure what set him off 100%, but it was second shift, and he attacked staff with a pen. He stabbed a staff in the chest twice. He bit another staff. He hurts staff. He hurts staff more than anybody. He's the one that bothers me the most if he's upset with a client. I know what he's capable of, so I worry about that. I can get him to calm down, talking to him. I'll pull him off to a corner. I know the risk of what happened in January. I'll do everything I can to deescalate." RM #1 indicated client #18 was on 5-minutes checks and line of sight when he's not in his room. RM #1 indicated client #18 was not to have contact with client #5. RM #1 indicated on Saturday, 7/23/22 DSP #4 reported to her an allegation of sexual inappropriate behavior by client #18 toward client #5. RM #1 indicated client #5 had reported to DSP #4 an allegation of sexual assault by client #18 while he was in the pacer unit shower the morning of 7/23/22. RM #1 indicated the allegation was on 3rd shift when he got up but was unable to give a specific time. RM #1 stated, "Just before lunch on that Saturday, I was writing some notes in the RM book, [DSP #4] came in and said [client #18 and client #5] had			

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	hugged in the day room. [Client #18] had reached down, and I'm not sure which hand, but [client #18] had groped [client #5's] genitals. [Client #5's] parents were visiting. Right before the parents got here, [client #5] stayed pretty mellow. He said he was upset about it. It was right at lunch time, after lunch, everything else transpired where the allegations of rape transpired." RM #1 indicated client #5 reported client #18 had been sexually assaulting him between a year and half and two years. RM #1 stated, "He said he did not come to us because the staff he thought he could trust let him down." RM #1 stated, "[Client #5] initially reported to [DSP #17] at least over a year ago. [DSP #17] just looked at [client #18] and, not a full on smack, but a little tap on the hand and said don't do it again." RM #1 stated, "Their visit was in the rec room. It was after they (parents) left, that she spoke to me about it. I wasn't aware of anything before the parent visit other than the alleged groping." RM #1 indicated she had received a text message on 7/23/22 at 12:21 PM. RM #1 indicated the text message reported client #18 had smacked client #5 on his buttocks after prompting to not be inappropriate. RM #1 stated, "[Client #18] pulled [client #5] behind staff and tickled and played with his penis. I texted [PM]. She had me put it as client to client IR (Incident Report) where to			

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	talk to the client to get their side of the story and ABC (Antecedent Behavior Consequence) track it. It's going on the yellow sheet regardless. That's when I asked [DSP #4] to sit with him to get a statement. [DSP #4] interviewed [client #5]. I interviewed [client #12] on the backside of the office." RM #1 stated, "At that point, I was informed it was a situation with [client #12] as well. [Client #5] told [DSP #4] that [client #18] came into the room and told [client #12] he needed to leave. [Client #12] said it was after [client #18] had tried to initiate sexual contact with [client #12]. [Client #18] left [client #12] and went to [client #12's] bed. It was reported [client #12] was asleep. [Client #12] told me [client #18] woke [client #5] up with oral sex. That's when [client #12] was told to leave the room." RM #1 stated, "The time frame, usually 2nd shift does green books around 10 PM to around the beginning of third shift. There are times at shift change, it is kind of chaotic. [Client #18] just slides through the crowd and goes right down to the room."RM #1 stated, "[Client #18] is not allowed to be in other people's rooms, absolutely not. In the hallway, he can talk to someone, as long as someone is watching to make sure he doesn't go in there. I try to keep interaction in the day room only."RM #1 stated, "[Client #5's] made numerous			

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	comments about not being safe. They've been written up. He'll go down to the end of Pacer hall and will cry for a few minutes. He'll say I don't feel safe. He'll never say why. He'll say he wants to leave."RM #1 stated, "It was reported to me by [client #14] (that) [client #18] was bragging about thinking how he wants to rape multiple clients. [Clients #9, #21, #11 and #7]. There was a previous incident, a little over a year ago. [Client #7] and [client #11] were allowed to be in [client #18's] room with [client #5]. I took the report the next day when I got to work. [Client #7] was terrified. He was across the hall from [client #18]. He alleged [client #18] claimed he was going to rape him if he told anyone what was said and done in that room that night. I reported to my RM (former staff). He didn't report it. [DSP #17] was on shift that night and told them they could all be in [client #18's] room together." RM #1 stated, "[Client #18] likes to hug a lot. He'll walk up to anyone and put his arms around them. A few days prior to this report to [PM], [DSP #19] reported to me, before he got there, about 2 am, whatever day it was. A fire alarm went off. It wasn't a planned fire drill. On the walk back over, [DSP #18] was holding the door open for the guys to go back in the building. [Client #18] was holding [client #1's] hand and walked into			

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	his room with him. I reached out to [PM] and let her know what was going on."DSP #3 was interviewed on 8/2/22 at 11:27 AM. DSP #3 indicated she had worked at the facility since 2019 and had transferred to a waiver home after client #5's allegations regarding client #18. DSP #3 indicated she continued working with client #5 as a waiver staff while client #5 participated in programming activities at the facility. DSP #3 stated, "He didn't say anything to me, I've just heard what's going around. The first story I heard was him and [client #18] were boyfriends. Then he said [client #18] raped him. I wasn't here when it happened."When asked if client #5 was able to give consent or vulnerable, DSP #3 stated, "Yeah, I think he is. I know [client #5] pretty good. When he's upset, it's usually about his family. He's very sensitive. I don't know if he fully understands." DSP #3 indicated client #18 was on 15-minute checks but she was unsure if this was continued. DSP #3 indicated client #18 was on line of sight supervision. DSP #3 stated, "Sometimes we're short handed, and it's hard. When you have a 1:1, it's hard to do." DSP #3 indicated client #4 was a 1:1 and client #3 was on line of sight supervision. DSP #3 indicated client #18 utilized the bathroom in the hallway and not the shared bathroom in his bedroom. DSP #3 stated, "[Client #18's]			

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	not supposed to be in other clients' rooms. I've caught him. Maybe 3 weeks ago I caught him trying to go into [client #12's] bedroom. No one is supposed to go in anyone's bedrooms." DSP #3 stated, "I've heard he's threatened others, but I don't know. I heard he was going to go after [client #14], sexually. Some of the lower functioning guys (like) [client #3] who can't talk, [client #17], [client #4]. They're in his hall."When asked if clients #3, #4 and #17 were safe, DSP #3 stated, "If they were in a different hall. [Client #18] is in the same hall, if they were in a separate hall, I would feel more comfortable. In my opinion, they're not safe."LPN (Licensed Practical Nurse) #2 was interviewed on 8/2/22 at 2:54 PM. LPN #2 stated today the unit was "Very loud, unorganized. I can hear it. They have asked for help before. They didn't today. Today was chaotic. One of the most chaotic I've ever seen here. I've been here 6 years." LPN #2 stated, "I've never seen [client #4] so hyper. A lot of times when new people are in the building, clients are attention seeking more. I feel like [client #3] needs to be a 1:1. Staff are overwhelmed with trying to keep an eye on him. He's in and out of everyone's rooms. He could be eating something he shouldn't be eating. He doesn't have any safety. He's not safe. I think that's a lot of the chaos." LPN #2 stated, "The			

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	clients all feed off of it. Then we had a staff lose his temper and was screaming. He raised his voice. I came out of the nurses station. It happened again. I heard [RN (Registered Nurse), and I heard screaming in the background."Confidential Interview A stated, "I don't understand why [client #18's] still here. I don't understand what we can do for him. He's stabbed a staff. He's broken a staff's arm. He's accused staff of misconduct. He has all kinds of allegations, sexual stuff." Confidential Interview A stated, "[Client #18's] known for stealing. He was on a rampage saying he was going to get staff fired. He's been here a long time. I don't feel like we're helping him at all. He'll go for a long time and be fine, then he snaps. He bit a tattoo off the staff's arm. Another girl has a huge scar where he had bit her, too. I'm scared to death to be by myself with him."Confidential Interview A stated, "I don't feel like anyone is safe around him."Observations were conducted at the facility on 8/2/22 from 11:58 AM through 1:00 PM. At 11:58 AM, clients #6, #16, #18 and #19 were seated at a table in the dining room area. Client #10 was seated at a table next to client #18. The dining room area and dayroom area were the same open space. The unit was loud with constant movement of staff and clients between the dayroom, dining area and kitchen. The noise			

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	level was loud. Client #3 was constantly pacing the dayroom, hallways, entering client bedrooms and the dining room area. Client #4 was engaged in behavior throughout the observation attempting self-harm, loud yelling and staff redirection. At 12:10 PM, client #18 encouraged clients #6 and #19 to hold hands while seated at the table across from him. Client #6 held client #19's hand, placed his hand up to his facial area, kissed his hand and caresses his hand while client #18 encouraged the behavior and laughed. At 12:17 PM, client #18 was seated directly across the dining room table from client #6. Client #18 held client #6's hands with both of his hands while stroking and pulling on client #6's fingers. Staff working in the area were engaged in meal preparation and managing client #3 and #4's behavior. No staff redirected client #18. At 12:23 PM, client #8 stood up from the dining room table and used his hands to cover both of his ears. Client #8 then walked out of the dining room to his bedroom with his hands covering his ears. At 12:40 PM, client #18 turned to his right side where client #10 was seated. Client #18 rubbed client #10's back and then held client #10's left hand. No staff redirected client #18. Client #8 was interviewed on 8/2/22 at 12:35 PM. Client #8 indicated the dining room was loud. Client #8 indicated he did not like the loud			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES-CARE INC	1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135

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	noise level and covered his ears. Client #5's record was reviewed on 8/4/22 at 3:07 PM. Client #5's CFA (Comprehensive Functional Assessment) dated 10/18/21 included a Human Development Section and indicated the following:-"15. Expresses understanding of an orgasm. No.16. Expresses interest in developing a sexual relationship. No.17. Expresses interest in learning more about social/sexual behavior their body, feelings, etc. (sic). No."-"19. Expenses sexual attraction. No.20. Has a girlfriend/boyfriend/serious partner. No."-"24. Says 'No' to unwanted sexual advances. Yes."-"26. Calls for help when bothered. Yes.27. Approaches others for sex or touch. No.28. Expresses interest in dating. No."Client #18's record was reviewed on 8/4/22 at 3:55 PM. Client #18's BSP dated 7/13/22 indicated the following:-"Inappropriate Sexual Behaviors: defined as exposing his genitals to others in public places, touching others' private areas, rubbing himself on others, or making verbalizations/gestures of a sexual nature to others in a common area. Also includes masturbating in public areas. Historical documentation indicates that [client #18] tends to look for opportunities to sexually act out with his peers. He has followed peers into the restroom or into their bedrooms in the past."-"Boundary			

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	Violations: defined as hugging others without permission, rubbing the backs/arms/bodies of others or invading the personal space of others. Includes acts of tickling or poking others. [Client #18] has demonstrated boundary violations against both staff and peers."-"He will have 15 minute checks while inside the residential building."-"[Client #18] will not be in the bedrooms or doorways of his peer's rooms (target behavior: theft, sexually inappropriate behaviors)."-"There will be a lock on the pass-through bathroom so that [client #18] cannot enter his peer's bedroom through the shared bathroom (target behavior: theft, sexually inappropriate behaviors)."Client #18's BSP revised date 7/27/22 indicated the following:-"Due to sexually inappropriate behaviors with peers, [client #18] will remain in line of sight whenever he is out of his bedroom, including outside. He will have 5 minute checks while in his bedroom."-"Due to sexually inappropriate behaviors with peers, [client #18] will not have access to his shared bathroom and he will use the hallway bathroom. Staff must check the bathroom prior to [client #18] entering to make sure no other peer is in the restroom."Client #18's IDT note dated 7/26/22 indicated the following:-"On July 23, 2022, at 3 PM, [client #5] reported to staff that he allegedly had been sexually assaulted by [client #18].			

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	[Client #5] was transported to [first emergency room] for an examination then transferred to [second emergency room] due to not having a sex assault examiner on shift. While at [first emergency room] [client #5] and staff both gave statements to the [police] and a police report was filed. The forensic rape examination was performed and [client #5] was released from the hospital."-"Recommendations: Discussed 1 to 1 staff to client ratio and meeting with [counselor] on 8/2/22 due to previous request and due to increase in sexual preoccupation."-"[Client #18] will not have access to his bedroom's shared bathroom and will use the hallway bathroom at this time." Client #5's BSP (Behavior Support Plan) dated 7/20/22 indicated the following: -"His mother is [guardian] and she has recently become [client #5's] guardian."-"Staff are to be within earshot of the door when [client #5] is in the shower in case he calls out for help as he has a history of seizures that result in falls. Staff should pay attention to potential sounds of a fall or seizure activity."The review indicated client #5 had a target behavior of false reporting emergencies to 911. The review did not indicate documentation of false reporting of allegations of abuse, neglect or mistreatment. The review indicated client #5 had a legal guardian. Client #5's IDT (Interdisciplinary			

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	Team) form dated 7/26/22 indicated the following:-"On July 23, 2022, at 12:06 PM, while in the dayroom peer smack [client #5] on his buttocks; peer was verbally redirected and educated on boundaries. Peer then walked behind staff and then hugged [client #5] and then touched the outer part of the pants on his groin area. Peer was educated on personal space and redirected to another area. On July 23, 2022, at 3 PM, [client #5] reported to staff that he allegedly had been sexually assaulted by [client #18]. [Client #5] was transported to [first emergency room] for an examination then transferred to [second emergency room] due to not having a sex assault examiner on shift. While at [first emergency room] [client #5] and staff both gave statements to the [police] and a police report was filed. The forensic rape examination was performed and [client #5] was released from the hospital."-"[Client #5] has been offered emotional support. [Client #5] with team/guardian approval has been moved to a different building. [Client #5] and [client #18] will remain separated until further notice. [Client #5] will receive one on one staff supports while staying in alternative building. [Client #18] will receive 5-minute checks while in his bedroom and line of sight when out of his bedroom. [Client #18] does not have a roommate. Both individuals are			

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	scheduled to meet with the detective separately on 07/25/22 to provide further statements. ResCare will cooperate with the [police department's] investigation. ResCare has also initiated an investigation. The administration team including Executive Director were notified. IDT team meeting to be held for both individuals to discuss further protective and preventative measures."PM (Program Manager) was interviewed on 8/3/22 at 10:32 AM. PM indicated RM #1 called and reported an allegation of sexual assault on 7/23/22 regarding clients #5 and #18. PM indicated she called and spoke with client #5. PM indicated client #5 returned from a family visit and reported client #18 had assaulted him. PM indicated client #5 had not reported the allegation to his family during the visit. PM indicated client #5 reported the allegation to a detective while at the hospital. PM indicated client #5 reported to the detective client #18 had come in his room and had anal sex with him. PM indicated client #5 reported this happened more than once and client #5 told client #18 to stop. PM indicated client #18 denied the allegations but did make statements about masturbating with client #5 while client #12 watched for staff. PM indicated client #5 was afraid of client #18. PM indicated client #5 had a guardian and would need consent to participate in a sexual			

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	relationship. PM indicated there was not an assessment, guardian or IDT review and consent available for review regarding client #5's ability to consent to sexual relationships. PM indicated client #18 was placed on 5-minute checks while in his room and on line of sight supervision while outside of his room. PM indicated line of sight meant to monitor and redirect client #18's behaviors. PM indicated client #18's boundary violations and touching his peer's should be redirected and documented as target behavior. PM indicated all allegations of abuse and neglect should be reported to the administrator immediately and to BDDS within 24 hours. PM indicated allegations should include the circumstances, who, what, when, where and how of alleged incidents. PM indicated allegations should be thoroughly investigated within 5 business day and include corrective measures to prevent recurrence.BC was interviewed on 8/3/22 at 12:42 PM. BC indicated client #18's BSP was updated to include 5-minute checks while in his bedroom and line of sight supervision while outside of his bedroom. BC indicated client #18 would use the common shower and restroom and his bedroom shared restroom would be restricted. BC indicated client 18's line of sight supervision was assigned by the RM at the beginning of the shift. When asked if line			

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	of sight was an effective intervention for client #18, BC stated, "Depends on the staff implementing it. [Client #18] is very clever." BC indicated the IDT had discussed making client #18 a 1 to 1 staff to client ratio supervision to prevent targeting other clients. BC indicated 1:1 supervision had not been implemented. Client #5 was interviewed on 8/1/22 at 1:00 pm and stated, "I need to tell you about the incident in the shower. [Client #18], he literally raped me. I had to go get checked out at the hospital. They couldn't do it in the hospital here, so I had to go to [town]." Client #5 stated, "I didn't hit him. I tried to push him off of me. I'm going to a waiver home. They're still investigating." Client #5 indicated he did not know if client #18 had targeted any other clients. Client #5 stated, "He gives everyone hugs and handshakes." Client #5 stated, "It happened [7/23/22]. Staff were busy doing paperwork, so no one heard me. I'm stressed out thinking, 'Who's he going to do it to next?'"Client #5 stated, "I was in the shower. I was undressed." Client #5 indicated client #18 touched his genitals. Client #5 indicated client #18 pushed him into a wall from behind. Client #5 indicated client #18 was not dressed. Client #5 stated, "He was sticking his penis in my butt." Client #5 stated, "[Client #18] said he will get [client #12] next then [client #7]. He			

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	said if I tell anyone, he'll kill me." Client #5 stated, "Staff didn't come in. They were busy. When he was done, he went out of the bathroom." Client #5 stated, "I told [DSP #4], [RM #1], and [RM #2]. It was on second shift." Client #5 stated, "[RM #1] took me to the hospital here, but they couldn't do it, so [DSP #4] took me to the hospital in [town]." Client #5 indicated the hospital did not mention any bruises or bleeding. Client #5 indicated he was not longer staying in the facility.Client #12 was interviewed on 8/1/22 at 6:33 pm and stated, "[Client #5] is gone. He went to waiver. I don't remember when. A couple of days ago." Client #12 stated, "I'm not friends with [client #18] because of the incident that happened with [client #5]." Client #12 stated, "When I sit next to [client #18] at the table, he keeps grabbing my legs and stuff. That's why I moved at breakfast, because he did it." Client #12 stated, "I'm trying to stay to myself. I want to move out of here." Client #12 stated, "He said he's going to grab my a**. Staff has wrote (sic) him up before." Client #12 indicated he did not want to talk about the allegation between clients #18 and #5 but would answer questions with yes and no.When asked if client #18 had entered clients #12 and #13's shared bedroom while they were asleep, client #12 stated, "Yes."When asked if he			

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	had seen client #18 expose himself to others, client #12 stated, "Yes."When asked if he had seen client #18 ask client #5 for oral sex, client #12 stated, "Yes, [client #5] told him no multiple times. He did it anyway."When asked if he was afraid of client #18, client #12 stated, "Yes. A lot of people are afraid of [client #18] because of how violent he's gotten. Two old staff, he attacked both of them. He stabbed one in the chest and put the other's head through the wall. I'm scared of him. I don't want to be around him." Client #12 stated, "The day I ran away was because of him. It was a month ago. We dug a hole under the fence. [Client #18] talked me into it. It was his idea. I shouldn't have followed him, but I did. I was being stupid. Once we got out, we split up. Staff found me with a tracker on my phone. I didn't know about it."Client #14 was interviewed on 8/32/22 at 1:27 pm and stated, "Last week, maybe the week before, [client #18] grabbed me by my area, he punched it and said if I didn't let him do anything to me, there would be consequences. I didn't say anything at first, he said he would rape me in my sleep that night. I did say something to [DSP #9]. He said he'd tell someone." Client #14 stated, "I was wearing clothes. He kind of tricked me. He said, 'Come here and look at what I'm looking at.' There was nothing there. It			

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	was in the kitchen, in the corner where the cameras wouldn't see. That's when he caught me off guard." Client #14 indicated his bedroom was in the same hallway as client #18's.Client #14 stated, "Nothing has happened before or since. He's gotten close and tried to hug, but I don't let him. I don't like that." Client #14 stated, "He has tried to go in my bedroom. He tries to steal from me. He waits until I'm not in the room or are asleep. Staff don't notice. They would say something if they did." Client #14 stated, "I'm not afraid of him. I think he might try to do something to me." Client #14 explained he would defend himself against client and graphically described a plan to kill client #18 if needed. Client #14 stated, "It's too much here. All of the chaos. People like [client #18]. I need out of here. I don't feel safe here."RM #4 was interviewed on 8/2/22 at 7:33 am and stated, "I'm an RM. We manage the floor. We're in charge of the staffing. Being the lead, if there's a behavior, we set up. We make sure we have staffing and ratio if there are appointments. If someone doesn't show up, we have to find someone or stay ourselves. We're working overtime. Lots of it." RM #4 stated, "[Client #3] is line of sight. [Client #18] is line of sight when he's out of his room with 5 minute checks when he's in his room. We've reimplemented that. He's been on it before,			

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	but we just put it back into place. [Clients #4 and #13] are 1 to 1."RM #4 stated, "There were allegations with [client #18] and [client #5] that they had sexual relations." RM #4 s			
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 immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 2 additional clients (#5 and #18), the facility failed to report an alleged sexual assault and inappropriate sexual behavior by client #18 against client #5. Findings include: DSP (Direct Support Professional) #4 was interviewed on 8/1/22 at 4:16 PM. DSP #4 stated on Saturday, July 23, 2022, "I was in the dayroom working on paperwork while waiting for lunch to be served. I watched [client #18] smack [client #5] on his butt. I redirected [client #18]. They were standing by the tables when it happened." DSP #4 stated, "After redirecting, I noticed [client #18] walked around behind me where I was sitting and then I saw [client #5] go behind me. I turned around and saw [client #18] groping [client #5's] private parts with his left hand behind me. I redirected them and got the RM (Residential Manager), [RM #1] and told her about the situation. [Client #5] didn't want to talk about it." DSP #4 indicated client #5 then went on a visit with his guardian. DSP #4 indicated when client #5 returned from his visit he requested to speak	W 0153	**W 153** **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, direct support and supervisory staff have been retrained regarding required reporting criteria and timelines. **PREVENTION:** The Quality Assurance Manager or designee will 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.	08/29/2022

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	with her. DSP #4 stated client #5 returned from his visit at "approximately 2:40 PM and we went on the front porch with just him and I (sic). We started discussing the incident prior to his visit. I educated him on sexual inappropriate behavior and told him he should report it to staff. He told me it had happened before but didn't have an exact date. We tried to pinpoint a time but it had happened multiple times over the last few years. He said he had told staff before and [client #18] told him to keep his mouth shut." DSP stated client #5 reported "[Client #18] had come in his and [client #12's] bedroom and that [client #18] had pulled out his private and forced [client #5] to suck on it. [Client #5] was telling him no multiple times. [Client #18] had attempted it with [client #12] and he told him no. [Client #12] was left alone. [Client #12] was present in the bedroom when it happened. [Client #5] told me he was in the pacer's hall shower before 8 AM. [Client #18] entered the shower. [Client #18] had intercourse with him again and he told him no." DSP #4 stated client #5 reported "[Client #18] entered the shower and he told [client #18] no. Said that he tried to move away but was backed into a corner." DSP #4 indicated client #5 reported the day of the shower incident was 7/23/22. DSP #4 indicated the day of the bedroom incident was not able to be determined but was in July 2022. DSP #4 indicated she immediately reported the allegations to RM #1. DSP #4 indicated client #5 was taken to the hospital for a sexual assault examination. DSP #4 indicated client #5 was moved to another area of the building away from contact with client #18 and then was moved to a waiver home. DSP #4 indicated client #5 came to the agency campus during the day and did not have further contact with client #18. DSP #4 stated client #5 had "never lied to me in the time that I've known him. Other staff report he's a liar but I feel like he was being		Supervisory staff will review all facility documentation to assure incidents are reported as required. All staff, supervisory staff and administrative staff will be retrained on BDDS reporting criteria and timeframes. For the next 30 days, members of the Operations Team will conduct daily administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including weekend observations. After 30 days, administrative monitoring will occur no less than three times 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. Current Operations Team members received training from the Operations Support Specialist to assure a clear understanding of administrative monitoring as defined below. · 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	

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	honest. He had been depressed." DSP #4 indicated client #18 did not have special supervision or monitoring prior to the 7/23/22 incident. DSP #4 stated, "Personally, I would never have him around another peer. [Client #18] likes to make allegations. Any clients that can't talk. Any that are non-verbal like [client #10], [client #11], [client #19], [client #9]. Any that can be peer pressured. I wasn't present but it was reported [client #18] made a threat to rape [client #14] that night." DSP #4 indicated client #18's bedroom bathroom door was now locked and he was not allowed alone with any peers, and was in line of sight when he was outside of his bedroom. An additional IR (Incident Report) dated 7/23/22 was reviewed on 8/4/22 at 5:01 PM. The review indicated the following: -"On the above date and time (7/23/22 at 3 PM), [client #5] came to staff to report that he's been sexually assaulted. Staff began to take note of [client #5's] report. [Client #5] stated that over the course of the last 1.5 - 2 years [client #18] had been sexually assaulting him. [Client #5] stated that within the last 1-2 weeks while in his bedroom that between 8 PM and midnight while staff is switching over that [client #18] comes into his bedroom unnoticed then [client #18] tells [client #12] to leave the room and [client #18] proceeds to give [client #5] a [masturbating] has oral sex with [client #5] to wake him up then [client #18] places his penis inside [client #5] and sodomize [client #5] (sic). [Client #5] stated it happens frequently and the most recent incident took place [client #5] stated was 7/23/22 while [client #5] was in the shower in pacer's hallway (sic). [Client #5] stated that [client #18] entered the shower room and at that time [client #18] began to sodomize [client #5]. [Client #5] went on to state to staff that		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 **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Direct Support Staff, Operations Team, Regional Director, Operations Support Specialist **CORRECTIONS COMPLETED BY:** 08/29/22	

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	[client #18] told him and [client #12] both that if anyone found out that [client #18] would kill them both. [Client #5] stated he was scared to tell anyone after being threatened and a former staff that he did tell didn't do anything to protect [client #5]. [Client #5] stated while he was visiting with his parents on 7/23/22 he was going to tell his parents but got scared. But then came to report to staff. [Client #5] stated his roommate [client #12] was fully aware of [client #18] having oral sex and sodomizing [client #5] due to [client #18] making [client #12] leave the room while the assaults take place in [client #5's] bed. [Client #12] was also questioned by staff and [client #12] gave staff the same information that [client #5] had. At just shortly after 4 PM, after speaking to program manager, [client #5] was taken to [first emergency room] to be examined. [First emergency room] then sent [client #5] to [second hospital] to be examined by sex assault doctor. At 5:30 PM, [client #5] left [first hospital] and arrived at [second hospital] at 6:15 PM. [Police] was (sic) notified before transport and [client #5] and [RM #1] gave police statements and they will do follow up investigation upon results of assault testing. Further information will follow upon discharge from hospital." The facility's BDDS (Bureau of Developmental Disabilities Services) reports and Investigations reviewed on 8/1/22 at 2:10 PM. The review indicated the following: -"Describe the injury, condition or circumstance of the incident and the activities taking place immediately prior to the incident. Identify all participants and their involvement in the incident. Please be comprehensive but concise in explaining who, when, where, why, how and what was heard and/or observed."			

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	-BDDS report dated 7/24/22 indicated, "On July 23, 2022, at 3 PM, [client #5] reported to staff that he allegedly had been sexually assaulted by [client #18]. [Client #5] was transported to [first Emergency Room] for an examination then transferred to [second Emergency Room] due to not having a sex assault examiner on shift. While at [first Emergency Room] [client #5] and staff both gave statements to the [police] and a police report was filed. The forensic rape examination was performed and [client #5] was released from the hospital. And, [Client #5] has been offered emotional support. [Client #5] with team/guardian approval has been moved to a different building. [Client #5] and [client #18] will remain separated until further notice. [Client #5] will receive one on one staff supports while staying in alternative building. [Client #18] will receive 5-minute checks while in his bedroom and line of sight when out of his bedroom. [Client #18] does not have a roommate. Both individuals are scheduled to meet with the detective separately on 07/25/22 to provide further statements. ResCare will cooperate with the [police department's] investigation. ResCare has also initiated an investigation. The administration team including Executive Director were notified. IDT (Interdisciplinary Team) meeting to be held for both individuals to discuss further protective and preventative measures." The 7/24/22 BDDS report did not indicate documentation of reporting the circumstance of the incident and the activities taking place immediately prior to the allegations. The 7/24/22 BDDS report did not indicate documentation of			

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	identifying all participants and their involvement in the incident. The 7/24/22 BDDS report did not indicate documentation of explaining who, when, where, why, how, and what was heard and/or observed. Client #5's allegations as reported and known by the facility on the 7/23/22 at 3 PM Incident report were not reported to BDDS. ED was interviewed on 8/3/22 at 1:18 PM. ED indicated the initial allegation was client #18 had raped client #5. ED indicated client #5's recollection of the timeframes of the alleged incident was between 2-3 AM or 12:30 PM on 7/23/22. ED indicated client #5 alleged client #18 entered his room, jumped on him and penetrated his anus while he was telling him no. ED indicated he was not initially aware of the allegation of sexual assault in the shower room. ED indicated the BDDS report included the basics regarding staff notification, date and where client #5 was taken. ED indicated the BDDS report did not include the specific circumstances of the allegations. ED indicated allegations should be reported to BDDS, allegations should be thoroughly investigated within 5 business days and corrective measures should be developed and implemented to prevent recurrence. QIDP (Qualified Intellectual Disability Professional) was interviewed on 8/3/22 at 11:28 AM. QIDP indicated the 7/24/22 BDDS report regarding the 7/23/22 allegations did not describe the specific circumstances of the allegations in the narrative. PM (Program Manager) was interviewed on 8/3/22 at 10:32 AM. PM indicated all allegations of abuse and neglect should be reported to the administrator immediately and to BDDS within 24			

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	hours. PM indicated allegations should include the circumstances, who, what, when, where and how of alleged incidents. This deficiency was cited on 6/9/22. The facility failed to implement a systemic plan of correction to prevent reoccurrence. 5-1.2(24)(l)			
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 observation, record review and interview for 2 additional clients (#5 and #18), the facility failed to thoroughly investigate the alleged sexual assault and alleged inappropriate sexual behavior regarding client #5 by client #18. Findings include: An IR (Incident Report) dated 7/23/22 was reviewed on 8/4/22 at 5:01 PM. The review indicated the following: -"On the above date and time (7/23/22 at 3 PM), [client #5] came to staff to report that he's been sexually assaulted. Staff began to take note of [client #5's] report. [Client #5] stated that over the course of the last 1.5 - 2 years [client #18] had been sexually assaulting him. [Client #5] stated that within the last 1-2 weeks while in his bedroom that between 8 PM and midnight while staff is switching over that [client #18] comes into his bedroom unnoticed then [client #18] tells [client #12] to leave the room and [client #18] proceeds to give [client #5] a [masturbating] has oral sex with [client #5] to wake him up then [client #18] places his penis inside [client #5] and sodomize	W 0154	**W 154** **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: ·Investigators to be retrained to identify additional allegations during the course of an investigation and to ensure that any additional allegations are reported appropriately, accurately and reported timely. ·Investigators to be retrained to complete investigations within 5 business of alleged incidents ·Investigators to be retrained on including recommendations to the investigation summary to prevent	08/29/2022

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	[client #5] (sic). [Client #5] stated it happens frequently and the most recent incident took place [client #5] stated was 7/23/22 while [client #5] was in the shower in pacer's hallway (sic). [Client #5] stated that [client #18] entered the shower room and at that time [client #18] began to sodomize [client #5]. [Client #5] went on to state to staff that [client #18] told him and [client #12] both that if anyone found out that [client #18] would kill them both. [Client #5] stated he was scared to tell anyone after being threatened and a former staff that he did tell didn't do anything to protect [client #5]. [Client #5] stated while he was visiting with his parents on 7/23/22 he was going to tell his parents but got scared. But then came to report to staff. [Client #5] stated his roommate [client #12] was fully aware of [client #18] having oral sex and sodomizing [client #5] due to [client #18] making [client #12] leave the room while the assaults take place in [client #5's] bed. [Client #12] was also questioned by staff and [client #12] gave staff the same information that [client #5] had. At just shortly after 4 PM, after speaking to program manager, [client #5] was taken to [first emergency room] to be examined. [First emergency room] then sent [client #5] to [second hospital] to be examined by sex assault doctor. At 5:30 PM, [client #5] left [first hospital] and arrived at [second hospital] at 6:15 PM. [Police] was (sic) notified before transport and [client #5] and [RM #1] gave police statements and they will do follow up investigation upon results of assault testing. Further information will follow upon discharge from hospital." The facility's BDDS (Bureau of Developmental Disabilities Services) reports and Investigations reviewed on 8/1/22 at 2:10 PM. The review indicated the following:		recurrence. ·Investigators to be retrained on interviewing all witnesses and potential witnesses ·All facility investigations will be completed by trained investigators. When incidents requiring investigation occur, the QA manager or designee will assign the investigation to a specific investigator. The QA manager or designee will conduct follow-up with the investigator to assure completion within required timeframes. **PREVENTION:** Investigations will be reviewed by the operations team to ensure timely completion, accuracy and thoroughness. A tracking system for implementation and completions of investigations has been initiated. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Direct Support Staff, Operations Team, Regional Director, Operations Support Specialist **CORRECTIONS COMPLETED BY:** 08/29/22	

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	-"Describe the injury, condition or circumstance of the incident and the activities taking place immediately prior to the incident. Identify all participants and their involvement in the incident. Please be comprehensive but concise in explaining who, when, where, why, how and what was heard and/or observed." -BDDS report dated 7/24/22 indicated, "On July 23, 2022, at 3 PM, [client #5] reported to staff that he allegedly had been sexually assaulted by [client #18]. [Client #5] was transported to [first Emergency Room] for an examination then transferred to [second Emergency Room] due to not having a sex assault examiner on shift. While at [first Emergency Room] [client #5] and staff both gave statements to the [police] and a police report was filed. The forensic rape examination was performed and [client #5] was released from the hospital. And, [Client #5] has been offered emotional support. [Client #5] with team/guardian approval has been moved to a different building. [Client #5] and [client #18] will remain separated until further notice. [Client #5] will receive one on one staff supports while staying in alternative building. [Client #18] will receive 5-minute checks while in his bedroom and line of sight when out of his bedroom. [Client #18] does not have a roommate. Both individuals are scheduled to meet with the detective separately on 07/25/22 to provide further statements. ResCare will cooperate with the [police department's] investigation. ResCare has also initiated an investigation. The administration team including Executive Director were notified. IDT (Interdisciplinary Team) meeting to be held for both individuals to discuss further protective			

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	and preventative measures." The facility provided an Investigation Summary dated 7/29/22 with the word 'Draft' written on it. The Investigation Summary dated 7/29/22 did not include documentation of a conclusion or recommendations. The 7/29/22 Investigation Summary did not indicate documentation of an addendum or extension. ED (Executive Director) via email on 8/2/22 at 10:53 stated, "Good morning, we will have the complete investigation and reviewed this afternoon at 3 PM. We had an extension to the addendum due to the scope of the investigation." An additional investigation summary was received via email on 8/2/22 at 2:54 PM. The Investigation Summary dated 7/29/22 signed on 8/2/22 indicated the following: -"Introduction On July 23rd, 2022, at 3 PM, [client #5] reported to staff that he allegedly had been sexually assaulted by [client #18]. [Client #5] was transported to [first emergency room] for an examination then transferred to [second emergency room due to not having a sex (sic) assault examiner on shift. While at [first hospital] [client #5] and staff both gave statements to the [police] and a police report was filed. The forensic examination was performed and [client #5] was released from the hospital." -"Scope of Investigation 1. Did Individual [client #18] sexually assault Individual [client #5]? 2. Has Individual [client #18] touched [client #5] in an unwanted, inappropriate manner? 3. Did Individual [client #5] consent to sexual acts with Individual [client #18]?			

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	4. Was Individual [client #18's] supervision level followed appropriately by staff? 5. Was Individual [client #5's] supervision level followed appropriately by staff? 6. Did staff fail to follow ResCare Policy and Procedures?" -"Investigative Procedure Physical/Demonstrative Evidence Documentary Reviews 1. Rest Assured Camera System-July 22 at Midnight until July 23 at 4 PM. 2. Staff Assignment Sheets- Staff assigned to staff for GOALS July 22 and July 23. 3. Progress Notes for Individual [client #5] dated July 23, 2022. 4. Progress Notes for Individual [client #18] dated July 23, 2022. 5. 5-minute Checks July 22 and July 23, 2022 6. Hospital Discharge Records for Individual [client #5] dated July 23, 2022. 7. Review Cell Phone Photo." -"[RM #3] On July 25th, 2022, [RM #3] stated that she is not aware of any inappropriate touching in anyway with any consumers. [RM #3] stated that [client #18] does enter everyone's rooms and get redirected to come back out. [RM #3] has never seen any clients doubled (sic) and or in the restrooms together at any time she has worked. [RM #3] stated that on July 21st, 2022, she witnessed [client #18] walking [client #1] in from a fire drill holding his hand to help him in the building and when she noticed she redirected him and asked what he was doing he stated I was putting him in his room he was scared (sic)." RM #3's witness statement form signed and dated on 7/25/22 indicated, "Stated on July 21st, 2022, I			

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	witnessed [client #18] walking [client #1] to his bedroom holding his hand. [RM #3] asked him what he was doing, [client #18] stated he was a tucking him into bed. She stated its late you shouldn't be in his room, I will tuck him into bed and [client #18] went to his room and shut his door (sic)." The Investigation Summary of RM #3's statement did not include details of client #18's actions inside of client #1's bedroom or client #18's stated intentions of tucking client #1 into his bed. -"On 7/28/22, [DSP #11] stated that he witnesses [client #18] horseplay all the time with clients but never inappropriate manner at all. [DSP #11] stated that he sees [client #18] enter clients' rooms and he will redirect him to get out. [DSP #11] stated that [client #18] could of went (sic) into someone's room for like 10 to 15 minutes a long time ago but doesn't remember the room. [DSP #11] stated that he has seen [client #18] enter [clients #5 and #12's] room but just stands at the doorway. [DSP #11] stated he has never seen any clients touching inappropriately at all." DSP #11's Witness Statement form was signed and dated 7/28/22 and indicated, "Does [client #18] go in everyone's rooms? Yes, could be in there for 10-15 minutes. What does he do? He talks to them." DSP #11's Witness form indicated, "Do you ever see him go into [client #5's] room? Yes, a few times. He is talking to [clients #5 and #12]." DSP #11's Witness form indicated, "Do clients have relationships? He stated awhile back that both [client #18] and [client #5] were dating." DSP #11's Witness statement and Investigation Summary were not consistent in the description of client #18's time of 10-15 minutes of being in			

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	clients #5 and #12's bedroom. The statement does not indicate documentation of a timeframe as described in the investigation summary. RM #3's investigation summary did not include details of client #18's actions inside of client #1's bedroom or client #18's stated intentions of tucking client #1 into his bed. -"On 7/23/22, [DSP #4] witnessed [client #18] at 12:06 PM smack [client #5] on his bottom, (sic) I educated [client #18] on sexual inappropriate behavior and personal space. [Client #18] then walked behind me and hugged [client #5]. I turned around to look behind me and witnessed [client #18] rubbing [client #5's] private area with his left hand. At this time, I educated [client #18] again on sexual inappropriate behavior and personal space. I then spoke with [client #5] and he told me he would like to speak to me after his visit with his mom and dad 12:50 PM. I reported to the RM, filled out the proper paperwork and went on about my day fulfilling my duties as a DSP. Once [client #5] returned from his visit at 2:20 PM, he had a snack and asked me to take him out on the front porch so we could speak in private. I told the RM what I was doing and I took [client #5] to the front porch. [Client #5] began talking about the incident that took place prior to his visit. [Client #5] informed me that [client #18] had raped him. I immediately reported these allegations to [RM #1] - the RM on duty. [RM #1] then contacted [PM (Program Manager)] to inform her of the situation. Then I had [client #5] write everything down. I followed the RM instructions. [DSP #4] took notes on 7/23 of [client #5] on the front porch bullet points -[Client #5] allegedly accusing [client #18] of rape more than once.			

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	-[Client #5] claims [client #18] has touched him inappropriately. -[Client #5] claims he has told [client #18] no each time. -[Client #5] claims [client #12] witnessed alleged accusations. -[Client #5] claims (the) most recent was in Pacer's shower room on third shift while [client #5] was showering. -[Client #5] claims he told [DSP #17] about the situation prior to him (sic/unknown) but [DSP #17] isn't here anymore. -[Client #5] claims he does not feel safe. -[Client #5] claims [client #18] threatened to kill both him and [client #12] if they told anyone. [DSP #4] took notes on 7/23 of [client #12] on the front porch bullet points -[client #12] claims the last 2 nights (7/22 and 7/23) [client #18] has come into his room after snack time and pulls his private parts out and makes [client #5] suck his private parts. -[client #12] claims [client #18] has had intercourse with [client #5] while [client #5] said no. -[client #12] claims [client #18] has humped him and asked for sex and [client #12] has refused. -[client #12] claims [client #18] say (sic) not to tell anyone or he will kill both of [client #12] and [client #5]. [DSP #11] when interview (sic) on 7/25/22, [DSP #11] (sic) stated she heard [client #5] talking with his mom on 7/23/22 around 2130 at night and [client #5 (sic)] mom asked him why he didn't tell her and [client #5] felt that he was being blamed." -"On 7/23/22 about 3 PM, my staff [DSP #11] came to me, [RM #1], and advised me about a sexual assault that not only had taken place on the date			

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	mentioned above (7/23/22) but also throughout the year and half. I then spoke to [client #5] and his roommate [client #12]. [Client #5] stated that [client #18] would sneak past staff at busy time in the evenings and go into [clients #5 and #12 (sic)] room. [Client #18] would then attempt to have a sexual encounter with [client #12] and when [client #12] would tell him no [client #18] would then move over to [client #5 (sic)] bed where he would force [client #5] for oral sex on [client #5] then [client #18] would force anal sex on [client #5]. [Client #12] stated to [RM #1] when interviewed separately from [client #5] the exact same story. I then called the [PM] to let her know of the situation." -"[RM #1] stated that [client #12] has come to staff I believe on the 2nd shift and stated that [client #18] sent me nude photos. [RM #1] states that [client #18] has sent [client #12] text that stated 'I will suck your [penis]' (this has been recently written up). [RM #1] states that on 7/23/22 [client #12] received a picture of his [penis] to (sic) his phone. [RM #1] stated that on 7/23/22 that once [clients #5 and #12] spoke to me [client #5] went and barricaded himself in his room. [RM #1] states that [client #5] took apart his fan for protection against [client #18]." -"[RM #1] states that she heard several months when [DSP #17] was here that [client #12] was so tired of getting messages from [client #18] (sic)." RM #1's Witness statement form signed and dated 7/25/22 indicated, "I have watched [client #18] on second shift attempt to enter into [clients #5 and #12's] room when [client #18] would apparently think staff was not watching. I have			

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	prompted [client #18] multiple times to stay of out of peers rooms and there are no other instances to my knowledge. [Client #5] has also previously stated he didn't feel safe at the facility when I spoke to [client #5] he would never tell me exactly why due to being scared of being seriously injured by [client #18] as [client #5] stated to us, 'I know what he did to my staff when he stabbed them (sic).'" The review did not indicate documentation of RM #1's statements regarding client #18's attempts to enter clients #5 and #12's bedroom and statements of feeling unsafe due to client #18's physical aggression towards former staff. -"On 7/28/22 [AD (Activity Director)] stated she has never seen [client #18] enter other clients' rooms but she stated he likes to stand at the doorways of them and talks with other consumers. [AD] stated that she has never seen [client #18] enter [client #5's] room at any point. [AD] stated that she has witnessed them hugging in the dayroom before dinner and she stated that she would redirect them. [AD] made a statement that she has heard over the course of a year that [clients #5 and #18] have been dating but never seen (sic) anything between them." -"On 7/28/22 [DSP #16] stated that over her few months work with ResCare never seen (sic) [client #18] enter [client #5] or [client #12] room She stated that she sees [client #3] enter everyone's room as he just runs in and runs right back out. [DSP #16] stated that she has seen [client #18] come out of consumers room (sic) she stated only on Sunday when he was asking where [client #5] was. [DSP #16] stated she is not aware of anyone having any relationships and or any inappropriate touching."			

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DSP #16's Witness statement form was signed and dated on 7/28/22. DSP #16's witness statement form indicated, "Have you ever seen [client #18] go in rooms? No, but I see (sic) him come out. Have you ever seen [client #18] in [client #5] (sic) room? Yes, on Sunday he said he was looking for him."

DSP #16's investigation summary and witness statement were not consistent in documentation regarding client #18's coming out of client bedrooms.

-"On 7/28/22, [DSP #2] stated that he has never witnessed any inappropriate touching other than a hug at dinner time on occasion. [DSP #2] stated that he has seen [client #18] enter [clients #5 and #12] (sic) room all the time and when I see him go in, I redirect, and he comes right back out. [DSP #2] stated that [client #18] asks all the time how [clients #12 and #5] are if they are not in the building and when they will be back."

DSP #2's witness statement form signed and dated 7/28/22 indicated, "Have you ever witnessed [client #18] or [client #5] touch? No, they do give hugs at dinner but that's all. When they hug its for a long period of time I have seen [client #18] enter [clients #5 and #12] (sic) room almost every time I work, When I see him, I redirect he doesn't go all the way in (sic). He always wants to know is going on with [clients #5 and #12]." DSP #2's witness statement form dated 7/28/22 indicated the statement was documented by ED via telephone call. The witness form had a written statement by DSP #2 on the back of the page. The written statement indicated, "I have been seeing [client #18] go into [clients #5 and #12's] room to see what's going on in there. I had asked [client

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	#18] what he needed, and he states he's just checking something. [Client #18] does it one or so (sic) every day I work." DSP #2's investigation summary, witness statement and written witness statement forms were not consistent in documentation of DSP #2's testimony. -"On 7/25/22, [client #5] states that he told staff that [client #18] was being sexual with him. [Client #5] stated that [client #18] was sending pictures and stuff to my phone. [Client #5] stated to staff that he didn't feel safe anymore. [Client #5] states that it was around 2 AM, [client #18] came into my room and got on top of me and whipped out his [penis] and started to masturbate on me. [Client #5] (stated he) then put his penis inside me for about 20 minutes. [Client #5] stated he has told [client #18] no before." -"On 7/25/22, [client #12] stated on Saturday the (7/23/22), [client #12] stated (sic) afternoon at about lunch time [client #18] came into [client #5] and I room (sic) and he jumped on [client #5] and told him to pull his pants down. [Client #18] was in our room for about 30 minutes. [Client #12] states that he was back and forth between being awake and sleep, (sic) [client #12] states that when [client #18] realized I was waking up he jumped up and ran out of the room. [Client #12] states that [client #5] kept yelling 'No' but [client #18] doesn't listen to anybody. [Client #18] states nothing happened during the overnight hours leading up to Saturday afternoon. On 7/28/22, [client #12] stated that [client #18] came into our room and I was half asleep and [client #18] came into our room and I was half asleep and [client #18] told [client #5] to pull his			

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	pants down and [client #18] sucked [client #5] penis. States that [client #18] wouldn't get off him. It has never happened before. [Client #12] states last time he saw it was a couple of weeks ago. [Client #18] ran into our door and wouldn't let [client #5] out, he wanted to talk to him and [client #18] were having sex and [client #5] stated to get off me when I walked in (sic). [Client #12] states that he has never seen them in the shower together. [Client #12] states one time he came into his room and [client #5] and [client #18] were having sex and [client #5] stated to get off me when I walked in. [Client #12] states that [client #18] has sent him pictures on his phone and I have attempted to delete them and I can't figure it out. [Client #12] showed [ED] the pictures on his phone. [Client #12] stated that he has heard that [clients #18 and #5] are dating but [client #5] tells me they are not. [Client #12] states sometimes I have run into my bathroom when [client #18] comes in our room and sit on the floor because I was scared. I would hear [client #18] and [client #5] doing things but I have never distracted staff so they could do things." -"On 7/28/22 [client #18] states he doesn't go into anyone's room, I like to stand at the doorways. [Client #18] states that he doesn't touch anyone inappropriately other than [client #5]. [Client #18] states that [client #5] lets me [masturbate him] and [oral sex]. [Client #18] states that we have been together a long time before ResCare. [Client #18] states that [client #12] distracts staff so me and [client #5] can [masturbates] each other. [Client #18] states that [client #5] [masturbates] and I sometimes [perform oral sex] because he is my boyfriend. [Client #18] states last time we did it was [client #18] thinks it was Thursday or Friday. [Client #18] states that 3 or 4 months ago I was in the shower and [client #5] came and told me to			

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	[perform oral sex]. [Client #18] states he did it while he was on the shower chair. [Client #18] states on Saturday [client #12] was mad cause I wouldn't [masturbate] him off. [Client #18] told [client #12] I couldn't do that I am with [client #5]. [Client #18] states I am bi-sexual. [Client #18] states [client #12] has sent him videos of girls with big [vagina with explicit description]. [Client #18] stated that sometime [client #12] will stay and watch and he [masturbates] while we are doing stuff." -"[Client #8] states that he has seen [client #18] and [client #7] in the shower before with the door open, they had their clothes on. I have never seen anything else between anyone ion (sic) the building." -"On 7/28/22, [client #14] states that he didn't see anyone go into [clients #12 and #5] room on Saturday 7/23/22. [Client #14] states that in the kitchen a long time ago that [client #18] grabbed his [testicles]. [Client #14] stated [client #18] said if you don't let me touch you then there will be consequences. [Client #14] states he has never done anything since that day but doesn't remember the day on our hallway (colts) but he says [client #18] will go into other client's room on the other hallway (pacer's). [Client #14] states he has never seen [client #18] or [client #5] touch each other at all." -"On 7/28/22, [client #7] states that no one has ever entered his room since he has changed rooms. [Client #7] stated over a year or more that [client #18] touched his penis but that was investigated, and nothing has happened since that day. [Client #7] stated he has seen [client #18] enter [client #5] room a few times but he just talks to them and staff get him out when they			

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	notice. [Client #7] states that he has never seen [client #18] or any clients dating each other at all." -"On 7/28/22, [client #15] states he has seen [client #18] enter [client #5] room several times and he says he went into his room at 6:30 PM on Saturday night. [Client #15] states I think he wanted to know if [client #5] was ok cause he wasn't in the building. [Client #15] states he has seen [client #18] touch other clients. [Client #15] states he likes to horseplay with everyone. [Client #15] stated that he sees [client #14] and [client #18] in everyone's rooms and they like to talk to everyone. [Client #15] stated nothing happened on Saturday the 23rd that he remembers." -"Factual Findings 1. [Client #14] states [client #18] has made threats related to sexually acts one time to him. 2. [Client #16] states the [client #18] enters [client #5] room for approximately 60 seconds and others room but nothing has happened. 3. [Client #19] states that [client #18] was seen entering [client #5] room for 2 seconds. 4. [Client #5] first interview (7/25/22) he stated [client #18] sent pictures to his phone, [client #18] masturbated on him, [client #18] had his penis inside of him for 20 minutes and he does not feel safe. 5. [Client #5] second interview (7/28/22) he stated he has never had sex with [client #18], [client #18] performed oral sex on him but they have never had sex. 6. [Client #12] states that while in the room, [client #18] jumped on [client #5] (who) kept yelling no. 7. [Client #18] denies going into anyone's room, he does not touch anyone inappropriately other than [client #5]. [Client #18] stated that he and [client #5] are 'together' and [client #12] distracts staff so that they can [masturbate] each other off.			

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	8. [AD] has heard [clients #5 and #18] are 'together' but has not seen anything occur between them. 9. [DSP #16] has never observed [client #18] enter [client #5] or [client #12] rooms and she is not aware of anyone being in a relationship. 10. [DSP #2] has not observed inappropriate touching and that he does see [client #18] enter [clients #5 and #12] room all the time but he comes right back out. 11. [RM #3] has not observed inappropriate touching and [client #18] enters everyone's bedroom but redirected to exit. 12. [RM #5] has not seen anyone going into other bedrooms at night and has not observed touching other individuals. [RM #5] heard a long time ago that [clients #18 and #5] are together as boyfriends. 13. [DSP #11] has not witnessed inappropriate touching. 14. [RM #2] states that he has not witnessed inappropriate touching. 15. [RM #4] states they position themselves in the hallway so there was no way something could have happened on third shift and she heard 4 months ago that [client #18] and [client #5] were dating. 16. [DSP #4] witnessed [client #18] smack [client #5] on his bottom, hug [client #5] and rub [client #5] private area. 17. [RM #1] stated [client #5] reported that [client #18] forced oral sex and anal sex with him and [client #12] reported the same. 18. Nude photos and sexually suggestive text messages were sent from [client #18] to [client #12] and [client #5]. 19. [Client #18] did not receive enhanced supervision at the time the alleged incident occurred. 20. [Client #5] did not receive enhanced			

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	supervision at the time the alleged incident occurred. 21. Camera footage on 7/23/22 revealed the following: -Footage shows at 12:06 PM shows [client #18] touching [client #5] in unwanted touch. -[Client #18] based off the camera footage does not go into [client #5] and [client #12] room upon [client #5] return from meeting with his guardians. -Based off camera [client #18] does go to [client #5] and [client #12] room but does not go into the room opens the door and shuts. 22. Per [police department detective] this investigation is ongoing. 23. The results of the [client #5] rape forensic examination have not yet been received. 24. Both clients have legal guardians. 25. According BSP [client #12] has target behaviors for telling stories that he will sometimes later recant. He is quick to do this if he feels that it will help him avoid getting into trouble. 26. According to BSP [client #5] has target behaviors for inappropriate sexual behaviors: defined as exposing his genitals to others in public places, touching other's private areas, rubbing himself on others, or making verbalization/gestures of a sexual nature to other in a common area. Also included masturbating in public areas. Includes attempt to remove the clothing of others. False reports/calls to 911: defined as any time he calls 911 and hangs up or any time that he calls 911 to make a false report. 27. According to BSP [client #18] has target behaviors for false reports/making hang up calls with 911: defined as any time he calls 911 and hangs up or any time that he calls 911 to make a false report. Boundary violations: defined as hugging others without permission, rubbing the backs/arms/bodies of others or invading the personal space of others. Included acts of flicking			

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	or poking others. [client #18] has demonstrated boundary violations against staff and peers." -"Conclusion 1. It is not substantiated that [client #18] sexually assaulted [client #5]. 2. It is substantiated that [client #18] touched [client #18] in an inappropriate manner. 3. It is not substantiated that [client #5] did not consent to sexually acts or to be touched by [client #18]. 4. It is not substantiated that [client #18] supervision level was not followed appropriately by staff. 5. It is not substantiated that [client #5] supervision level was not followed appropriately by staff. 6. It is not substantiated that staff failed to follow ResCare policy and procedure." The Investigation Summary did not include recommendations to prevent recurrence. PM via email on 8/5/22 at 12:44 PM indicated DSP #3, DSP #6, DSP #7, DSP #9, DSP #12, DSP #13, DSP #14 and DSP #18 worked at the facility on 7/22/22 and/or 7/23/22. The investigation summary did not include interviews with DSP #3, DSP #6, DSP #7, DSP #9, DSP #12, DSP #13, DSP #14 and DSP #18 as potential witnesses regarding client #5's 7/23/22 allegation of sexual assault by client #18. ED was interviewed on 8/3/22 at 1:18 PM. ED indicated he had completed the Investigation regarding client #5's 7/23/22 allegation of sexual assault. ED indicated the initial allegation was client #18 had raped client #5. ED indicated client #5's recollection of the timeframes of the alleged incident was between 2-3 AM or 12:30 PM on			

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	7/23/22. ED indicated client #5 alleged client #18 entered his room, jumped on him and penetrated his anus while he was telling him no. ED indicated the investigation was completed between 7/25/22 and 7/29/22 with the final investigation summary completed 8/2/22 at 3 PM. ED indicated he made recommendations to have client #18 be placed on 1 to 1 staff to client ratio supervision. ED stated he had made the recommendations based on "what I heard during the investigation that it would be one way to include (sic) the safety of the other clients. He's currently on 5-minute checks because of prior elopement." ED indicated his recommendations for 1 to 1 staff to client ratio supervision for client #18 had not been implemented. ED indicated he would need to follow-up with PM to begin implementation. ED state, "I don't believe he's targeting other clients. I heard of lot of hugging or horseplay but could be redirected. (Recommendation) basing it off of past history." ED stated, "He routinely enters other client bedrooms." ED indicated client #18 should not be in other clients bedroom as a part of ResCare's policy. ED indicated client #18's BSP did specify he should not be in bedrooms of his peer's. ED indicated he reviewed the agency's video monitoring system from 12 AM through 4 PM on 7/23/22. ED indicated he was not aware of any allegations prior to 7/23/22 at 12 AM. ED indicated client #5 had a guardian and would need guardian consent with the IDT to engage/consent to a sexual relationship/activity. ED indicated there was not IDT or guardian consent. ED indicated the investigation included allegations regarding client #18's use of his phone to send clients #5 and #12 explicit pictures and explicit messages. ED indicated he had recommended restrictions on client #18's personal phone. ED indicated there was not documentation of the cell phone restrictions recommendations included the			

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	15G811	A. BUILDING 00 B. WING	08/09/2022

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	investigation. ED indicated the investigation included factual finding #7. ED indicated factual finding #7 documented client #18's admission of touching client #5 due to being in a relationship. ED indicated the investigation included a conclusion #3. ED indicated conclusion finding #3 documented it was not substantiated client #5 did not consent to sexual acts or to be touched by client #18. ED indicated client #5 should not be dating other clients and did not have guardian and IDT support or approval to consent to being in a sexual relationship or acts. ED indicated he based the unsubstantiated on the sexual assault aspect. ED indicated the investigation included an interview with DSP # 4. ED indicated DSP #4's interview included allegations for the two nights prior to the 7/23/22 allegations. ED indicated he had reviewed the camera for 7/23/22 12 AM through 4 PM. ED indicated he substantiated the facility followed its policy and procedures. ED indicated allegations should be thoroughly investigated.QIDP (Qualified Intellectual Disability Professional) was interviewed on 8/3/22 at 11:28 AM.QIDP indicated he had been at the facility in the QIDP role since 7/22. QIDP indicated his primary role was as a Quality Assurance staff at another agency location. QIDP indicated he was an agency trained investigator. QIDP indicated he was assigned to assist with the investigation of client #5's 7/23/22 sexual assault allegations			

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	but was relieved from this role as ED (Executive Director) became the lead assigned investigator. QIDP indicated prior to being reassigned off the investigation he had begun a review of clients #5 and #18's BSP's, ISP's and daily progress notes. QIDP indicated he had completed an interview with client #5 prior to the ED taking over the investigation. QIDP indicated client #5 alleged the incident happened at 2 AM on 7/23/22. QIDP stated, "[Client #5] said that [client #18] just came in his room and got on top of him. Took his penis out and started masturbating on top of him and had intercourse with him. Told him no and he continued." QIDP stated, "[Client #12] alleged the incident happened at 12:30 PM or lunchtime on the 7/23/22. Basically said [client #18] came in their bedroom and had sex with him. [Client #5] repeatedly said no." QIDP indicated client #5 had a guardian and would need guardian consent to engage in a sexually active relationship or give consent. DSP (Direct Support Professional) #4 was interviewed on 8/1/22 at 4:16 PM. DSP #4 stated on Saturday, July 23, 2022, "I was in the dayroom working on paperwork while waiting for lunch to be served. I watched [client #18] smack [client #5] on his butt. I redirected [client #18]. They were standing by the tables when it happened." DSP #4 stated,			

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	"After redirecting, I noticed [client #18] walked around behind me where I was sitting and then I saw [client #5] go behind me. I turned around and saw [client #18] groping [client #5's] private parts with his left hand behind me. I redirected them and got the RM (Residential Manager), [RM #1] and told her about the situation. [Client #5] didn't want to talk about it." DSP #4 indicated client #5 then went on a visit with his guardian. DSP #4 indicated when client #5 returned from his visit he requested to speak with her. DSP #4 stated client #5 returned from his visit at "approximately 2:40 PM and we went on the front porch with just him and I (sic). We started discussing the incident prior to his visit. I educated him on sexual inappropriate behavior and told him he should report it to staff. He told me it had happened before but didn't have an exact date. We tried to pinpoint a time but it had happened multiple times over the last few years. He said he had told staff before and [client #18] told him to keep his mouth shut." DSP stated client #5 reported "[Client #18] had come in his and [client #12's] bedroom and that [client #18] had pulled out his private and forced [client #5] to suck on it. [Client #5] was telling him no multiple times. [Client #18] had attempted it with [client #12] and he told him no. [Client #12] was left alone. [Client #12] was present in			

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	the bedroom when it happened. [Client #4] told me he was in the pacer's hall shower before 8 AM. [Client #18] entered the shower. [Client #18] had intercourse with him again and he told him no." DSP #4 stated client #5 reported "[Client #18] entered the shower and he told [client #18] no. Said that he tried to move away but was backed into a corner." DSP #4 indicated client #5 reported the day of the shower incident was 7/23/22. DSP #4 indicated the day of the bedroom incident was not able to be determined but was in July 2022. DSP #4 indicated she immediately reported the allegations to RM #1. DSP #4 indicated client #5 was taken to the hospital for a sexual assault examination. DSP #4 indicated client #5 was moved to another area of the building away from contact with client #18 and then was moved to a waiver home. DSP #4 indicated client #5 came to the agency campus during the day and did not have further contact with client #18. DSP #4 stated client #5 had "never lied to me in the time that I've known him. Other staff report he's a liar but I feel like he was being honest. He had been depressed."DSP #4 indicated client #18 did not have special supervision or monitoring prior the 7/23/22 incident. DSP #4 stated, "Personally, I would never have him around another peer. [Client #18] likes make allegations. Any			

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	clients that can't talk. Any that are non-verbal like [client #10], [client #11], [client #19], [client #9]. Any that can be peer pressured. I wasn't present but it was reported [client #18] made a threat to rape [client #14] that night." DSP #4 indicated client #18's bedroom bathroom door was now locked and was not allowed alone with any peers, and was in line of sight when he was outside of his bedroom.RM (Residential Manager) #1 was interviewed on 8/1/22 at 5:17 PM. RM #1 indicated her role included ensuring staff implemented BSP's and ISP goals. RM #1 stated, "[Client #18] has massive behaviors. Around the end of January, he acted out. I'm not sure what set him off 100%, but it was second shift, and he attacked staff with a pen. He stabbed a staff in the chest twice. He bit another staff. He hurts staff. He hurts staff more than anybody. He's the one that bothers me the most if he's upset with a client. I know what he's capable of, so I worry about that. I can get him to calm down, talking to him. I'll pull him off to a corner. I know the risk of what happened in January. I'll do everything I can to deescalate." RM #1 indicated client #18 was on 5-minutes checks and line of sight when he's not in his room. RM #1 indicated client #18 was not to have contact with client #5. RM #1 indicated on Saturday, 7/23/22 DSP #4 reported to her an			

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	allegation of sexual inappropriate behavior by client #18 toward client #5. RM #1 indicated client #5 had reported to DSP #4 an allegation of sexual assault by client #18 while he was in the pacer unit shower the morning of 7/23/22. RM #1 indicated the allegation was on 3rd shift when he got up but was unable to give a specific time. RM #1 stated, "Just before lunch on that Saturday, I was writing some notes in the RM book, [DSP #4] came in and said [client #18 and client #5] had hugged in the day room. [Client #18] had reached down, and I'm not sure which hand, but [client #18] had groped [client #5's] genitals. [Client #5's] parents were visiting. Right before the parents got here, [client #5] stayed pretty mellow. He said he was upset about it. It was right at lunch time, after lunch, everything else transpired where the allegations of rape transpired." RM #1 indicated client #5 reported client #18 had been sexually assaulting him between a year and half and two years. RM #1 stated, "He said he did not come to us because the staff he thought he could trust let him down." RM #1 stated, "[Client #5] initially reported to [DSP #17] at least over a year ago. [DSP #17] just looked at [client #18] and, not a full on smack, but a little tap on the hand and said don't do it again." RM #1 stated, "Their visit was in the rec room. It was after they			

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	(parents) left, that she spoke to me about it. I wasn't aware of anything before the parent visit other than the alleged groping." RM #1 indicated she had received a text message on 7/23/22 at 12:21 PM. RM #1 indicated the text message reported client #18 had smacked client #5 on his buttocks after prompting to not be inappropriate. RM #1 stated, "[Client #18] pulled [client #5] behind staff and tickled and played with his penis. I texted [PM]. She had me put it as client to client IR (Incident Report) where to talk to the client to get their side of the story and ABC (Antecedent Behavior Consequence) track it. It's going on the yellow sheet regardless. That's when I asked [DSP #4] to sit with him to get a statement. [DSP #4] interviewed [client #5]. I interviewed [client #12] on the backside of the office." RM #1 stated, "At that point, I was informed it was a situation with [client #12] as well. [Client #5] told [DSP #4] that [client #18] came into the room and told [client #12] he needed to leave. [Client #12] said it was after [client #18] had tried to initiate sexual contact with [client #12]. [Client #18] left [client #12] and went to [client #12's] bed. It was reported [client #12] was asleep. [Client #12] told me [client #18] woke [client #5] up with oral sex. That's when [client #12] was told to leave the room." RM #1 stated, "The time frame,			

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	usually 2nd shift does green books around 10 PM to around the beginning of third shift. There are times at shift change, it is kind of chaotic. [Client #18] just slides through the crowd and goes right down to the room."RM #1 stated, "[Client #18] is not allowed to be in other people's rooms, absolutely not. In the hallway, he can talk to someone, as long as someone is watching to make sure he doesn't go in there. I try to keep interaction in the day room only."RM #1 stated, "[Client #5's] made numerous comments about not being safe. They've been written up. He'll go down to the end of Pacer hall and will cry for a few minutes. He'll say I don't feel safe. He'll never say why. He'll say he wants to leave."RM #1 stated, "It was reported to me by [client #14] (that) [client #18] was bragging about thinking how he wants to rape multiple clients. [Clients #9, #21, #11 and #7]. There was a previous incident, a little over a year ago. [Client #7] and [client #11] were allowed to be in [client #18's] room with [client #5]. I took the report the next day when I got to work. [Client #7] was terrified. He was across the hall from [client #18]. He alleged [client #18] claimed he was going to rape him if he told anyone what was said and done in that room that night. I reported to my RM (former staff). He didn't report it. [DSP #17] was on shift that night			

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	and told them they could all be in [client #18's] room together." RM #1 stated, "[Client #18] likes to hug a lot. He'll walk up to anyone and put his arms around them. A few days prior to this report to [PM], [DSP #19] reported to me, before he got there, about 2 am, whatever day it was. A fire alarm went off. It wasn't a planned fire drill. On the walk back over, [DSP #18] was holding the door open for the guys to go back in the building. [Client #18] was holding [client #1's] hand and walked into his room with him. I reached out to [PM] and let her know what was going on."DSP #3 was interviewed on 8/2/22 at 11:27 AM. DSP #3 stated, "He didn't say anything to me, I've just heard what's going around. The first story I heard was him and [client #18] were boyfriends. Then he said [client #18] raped him. I wasn't here when it happened."When asked if client #5 was able to give consent or vulnerable, DSP #3 stated, "Yeah, I think he is. I know [client #5] pretty good. When he's upset, it's usually about his family. He's very sensitive. I don't know if he fully understands." DSP #3 stated, "[Client #18's] not supposed to be in other clients' rooms. I've caught him. Maybe 3 weeks ago I caught him trying to go into [client #12's] bedroom. No one is supposed to go in anyone's bedrooms." DSP #3 stated, "I've heard he's threatened			

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	others, but I don't know. I heard he was going to go after [client #14], sexually. Some of the lower functioning guys (like) [client #3] who can't talk, [client #17], [client #4]. They're in his hall."When asked if clients #3, #4 and #17 were safe, DSP #3 stated, "If they were in a different hall. [Client #18] is in the same hall, if they were in a separate hall, I would feel more comfortable. In my opinion, they're not safe."PM (Program Manager) was interviewed on 8/3/22 at 10:32 AM. PM indicated RM #1 called and reported an allegation of sexual assault on 7/23/22 regarding clients #5 and #18. PM indicated she called and spoke with client #5. PM indicated client #5 returned from a family visit and reported client #18 had assaulted him. PM indicated client #5 reported the allegation to a detective while at the hospital. PM indicated client #5 reported to the detective client #18 had come in his room and had anal sex with him. PM indicated client #5 reported this happened more than once and client #5 told client #18 to stop. PM indicated client #18 denied the allegations but did make statements about masturbating with client #5 while client #12 watched for staff. PM indicated client #5 was afraid of client #18. PM indicated client #5 had a guardian and would need consent to participate in a sexual relationship. PM indicated there was not an assessment,			

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	guardian or IDT review and consent available for review regarding client #5's ability to consent to sexual relationships. PM indicated allegations should be thoroughly investigated within 5 business days.This deficiency was cited on 6/9/22. The facility failed to implement a systemic plan of correction to prevent reoccurrence. 5-1.2(24)(l)			
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 observation, record review and interview for 2 additional clients (#5 and #18), the facility failed to develop and implement effective corrective measures to prevent recurrence of client #18's alleged sexual assault and inappropriate sexual behaviors regarding client #5. Findings include: An IR (Incident Report) dated 7/23/22 was reviewed on 8/4/22 at 5:01 PM. The review indicated the following: -"On the above date and time (7/23/22 at 3 PM), [client #5] came to staff to report that he's been sexually assaulted. Staff began to take note of [client #5's] report. [Client #5] stated that over the course of the last 1.5 - 2 years [client #18] had been sexually assaulting him. [Client #5] stated that within the last 1-2 weeks while in his bedroom that between 8 PM and midnight while staff is switching over that [client #18] comes into his bedroom unnoticed then [client #18] tells [client #12] to leave the room and [client #18] proceeds to give [client #5] a [masturbating] has oral sex	W 0157	**W 157** **CORRECTION:** *If the alleged violation is verified, appropriate corrective action must be taken.* The governing body has determined that this deficient practice could affect all clients who reside in the facility. Specific corrections include: · Investigators to be retrained on including recommendations to the investigation summary to prevent recurrence. · Program Manager and QIDP to be retrained on developing and implementing effective corrective measures · Program Manager to be retrained to monitor the effectiveness of corrective measures that have been put into place.	08/29/2022

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	with [client #5] to wake him up then [client #18] places his penis inside [client #5] and sodomize [client #5] (sic). [Client #5] stated it happens frequently and the most recent incident took place [client #5] stated was 7/23/22 while [client #5] was in the shower in pacer's hallway (sic). [Client #5] stated that [client #18] entered the shower room and at that time [client #18] began to sodomize [client #5]. [Client #5] went on to state to staff that [client #18] told him and [client #12] both that if anyone found out that [client #18] would kill them both. [Client #5] stated he was scared to tell anyone after being threatened and a former staff that he did tell didn't do anything to protect [client #5]. [Client #5] stated while he was visiting with his parents on 7/23/22 he was going to tell his parents but got scared. But then came to report to staff. [Client #5] stated his roommate [client #12] was fully aware of [client #18] having oral sex and sodomizing [client #5] due to [client #18] making [client #12] leave the room while the assaults take place in [client #5's] bed. [Client #12] was also questioned by staff and [client #12] gave staff the same information that [client #5] had. At just shortly after 4 PM, after speaking to program manager, [client #5] was taken to [first emergency room] to be examined. [First emergency room] then sent [client #5] to [second hospital] to be examined by sex assault doctor. At 5:30 PM, [client #5] left [first hospital] and arrived at [second hospital] at 6:15 PM. [Police] was (sic) notified before transport and [client #5] and [RM #1] gave police statements and they will do follow up investigation upon results of assault testing. Further information will follow upon discharge from hospital." The facility's BDDS (Bureau of Developmental Disabilities Services) reports and Investigations reviewed on 8/1/22 at 2:10 PM. The review		**PREVENTION:** When significant incidents occur, including but not limited to injuries and exploitation and mistreatment the QIDP will contact front line team members and administrative staff as appropriate to convene an interdisciplinary team meeting to develop protective measures to help reduce and prevent further occurrences. The Program Manager or 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 skills training, including but not limited to assuring protective/preventive measures are implemented appropriately and effective. For the next 30 days, members of the Operations Team will conduct daily administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including weekend observations. After 30 days, administrative monitoring will occur no less than three times weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will	

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	indicated the following: -"Describe the injury, condition or circumstance of the incident and the activities taking place immediately prior to the incident. Identify all participants and their involvement in the incident. Please be comprehensive but concise in explaining who, when, where, why, how and what was heard and/or observed." -BDDS report dated 7/24/22 indicated, "On July 23, 2022, at 3 PM, [client #5] reported to staff that he allegedly had been sexually assaulted by [client #18]. [Client #5] was transported to [first Emergency Room] for an examination then transferred to [second Emergency Room] due to not having a sex assault examiner on shift. While at [first Emergency Room] [client #5] and staff both gave statements to the [police] and a police report was filed. The forensic rape examination was performed and [client #5] was released from the hospital. And, [Client #5] has been offered emotional support. [Client #5] with team/guardian approval has been moved to a different building. [Client #5] and [client #18] will remain separated until further notice. [Client #5] will receive one on one staff supports while staying in alternative building. [Client #18] will receive 5-minute checks while in his bedroom and line of sight when out of his bedroom. [Client #18] does not have a roommate. Both individuals are scheduled to meet with the detective separately on 07/25/22 to provide further statements. ResCare will cooperate with the [police department's] investigation. ResCare has also initiated an investigation. The administration team including Executive Director were notified.		determine the level of ongoing support needed at the facility. Current Operations Team members received training from the Operations Support Specialist to assure a clear understanding of administrative monitoring as defined below. · 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 oversight will include assuring that clients are placed in a socially and developmentally appropriate environment. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Direct Support Staff, Operations Team, Regional Director, Operations Support Specialist	

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	IDT (Interdisciplinary Team) meeting to be held for both individuals to discuss further protective and preventative measures." The facility provided an Investigation Summary dated 7/29/22 with the word 'Draft' written on it. The Investigation Summary dated 7/29/22 did not include documentation of a conclusion or recommendations. An additional investigation summary was received via email on 8/2/22 at 2:54 PM. The Investigation Summary dated 7/29/22 signed on 8/2/22 indicated the following: -"Introduction On July 23rd, 2022, at 3 PM, [client #5] reported to staff that he allegedly had been sexually assaulted by [client #18]. [Client #5] was transported to [first emergency room] for an examination then transferred to [second emergency room due to not having a sex (sic) assault examiner on shift. While at [first hospital] [client #5] and staff both gave statements to the [police] and a police report was filed. The forensic examination was performed and [client #5] was released from the hospital." -"Scope of Investigation 1. Did Individual [client #18] sexually assault Individual [client #5]? 2. Has Individual [client #18] touched [client #5] in an unwanted, inappropriate manner? 3. Did Individual [client #5] consent to sexual acts with Individual [client #18]? 4. Was Individual [client #18's] supervision level followed appropriately by staff? 5. Was Individual [client #5's] supervision level followed appropriately by staff? 6. Did staff fail to follow ResCare Policy and Procedures?"		**CORRECTIONS COMPLETED BY:** 08/29/22	

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-"Investigative Procedure
Physical/Demonstrative Evidence Documentary Reviews
1. Rest Assured Camera System-July 22 at Midnight until July 23 at 4 PM.
2. Staff Assignment Sheets- Staff assigned to staff for GOALS July 22 and July 23.
3. Progress Notes for Individual [client #5] dated July 23, 2022.
4. Progress Notes for Individual [client #18] dated July 23, 2022.
5. 5-minute Checks July 22 and July 23, 2022
6. Hospital Discharge Records for Individual [client #5] dated July 23, 2022.
7. Review Cell Phone Photo."

-"[RM #3]
On July 25th, 2022, [RM #3] stated that she is not aware of any inappropriate touching in anyway with any consumers. [RM #3] stated that [client #18] does enter everyone's rooms and get redirected to come back out. [RM #3] has never seen any clients doubled (sic) and or in the restrooms together at any time she has worked. [RM #3] stated that on July 21st, 2022, she witnessed [client #18] walking [client #1] in from a fire drill holding his hand to help him in the building and when she noticed she redirected him and asked what he was doing he stated I was putting him in his room he was scared (sic)."

RM #3's witness statement form signed and dated on 7/25/22 indicated, "Stated on July 21st, 2022, I witnessed [client #18] walking [client #1] to his bedroom holding his hand. [RM #3] asked him what he was doing, [client #18] stated he was a tucking him into bed. She stated its late you shouldn't be in his room, I will tuck him into bed and [client #18] went to his room and shut his

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	door (sic)." The Investigation Summary of RM #3's statement did not include details of client #18's actions inside of client #1's bedroom or client #18's stated intentions of tucking client #1 into his bed. -"On 7/28/22, [DSP #11] stated that he witnesses [client #18] horseplay all the time with clients but never inappropriate manner at all. [DSP #11] stated that he sees [client #18] enter clients' rooms and he will redirect him to get out. [DSP #11] stated that [client #18] could of went (sic) into someone's room for like 10 to 15 minutes a long time ago but doesn't remember the room. [DSP #11] stated that he has seen [client #18] enter [clients #5 and #12's] room but just stands at the doorway. [DSP #11] stated he has never seen any clients touching inappropriately at all." DSP #11's Witness Statement form was signed and dated 7/28/22 and indicated, "Does [client #18] go in everyone's rooms? Yes, could be in there for 10-15 minutes. What does he do? He talks to them." DSP #11's Witness form indicated, "Do you ever see him go into [client #5's] room? Yes, a few times. He is talking to [clients #5 and #12]." DSP #11's Witness form indicated, "Do clients have relationships? He stated awhile back that both [client #18] and [client #5] were dating." DSP #11's Witness statement and Investigation Summary were not consistent in the description of client #18's time of 10-15 minutes of being in clients #5 and #12's bedroom. The statement does not indicate documentation of a timeframe as described in the investigation summary. RM #3's investigation summary did not include details of client #18's actions inside of client #1's			

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	bedroom or client #18's stated intentions of tucking client #1 into his bed. -"On 7/23/22, [DSP #4] witnessed [client #18] at 12:06 PM smack [client #5] on his bottom, (sic) I educated [client #18] on sexual inappropriate behavior and personal space. [Client #18] then walked behind me and hugged [client #5]. I turned around to look behind me and witnessed [client #18] rubbing [client #5's] private area with his left hand. At this time, I educated [client #18] again on sexual inappropriate behavior and personal space. I then spoke with [client #5] and he told me he would like to speak to me after his visit with his mom and dad 12:50 PM. I reported to the RM, filled out the proper paperwork and went on about my day fulfilling my duties as a DSP. Once [client #5] returned from his visit at 2:20 PM, he had a snack and asked me to take him out on the front porch so we could speak in private. I told the RM what I was doing and I took [client #5] to the front porch. [Client #5] began talking about the incident that took place prior to his visit. [Client #5] informed me that [client #18] had raped him. I immediately reported these allegations to [RM #1] - the RM on duty. [RM #1] then contacted [PM (Program Manager)] to inform her of the situation. Then I had [client #5] write everything down. I followed the RM instructions. [DSP #4] took notes on 7/23 of [client #5] on the front porch bullet points -[Client #5] allegedly accusing [client #18] of rape more than once. -[Client #5] claims [client #18] has touched him inappropriately. -[Client #5] claims he has told [client #18] no each time. -[Client #5] claims [client #12] witnessed alleged accusations.			

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	-[Client #5] claims (the) most recent was in Pacer's shower room on third shift while [client #5] was showering. -[Client #5] claims he told [DSP #17] about the situation prior to him (sic/unknown) but [DSP #17] isn't here anymore. -[Client #5] claims he does not feel safe. -[Client #5] claims [client #18] threatened to kill both him and [client #12] if they told anyone. [DSP #4] took notes on 7/23 of [client #12] on the front porch bullet points -[client #12] claims the last 2 nights (7/22 and 7/23) [client #18] has come into his room after snack time and pulls his private parts out and makes [client #5] suck his private parts. -[client #12] claims [client #18] has had intercourse with [client #5] while [client #5] said no. -[client #12] claims [client #18] has humped him and asked for sex and [client #12] has refused. -[client #12] claims [client #18] say (sic) not to tell anyone or he will kill both of [client #12] and [client #5]. [DSP #11] when interview (sic) on 7/25/22, [DSP #11] (sic) stated she heard [client #5] talking with his mom on 7/23/22 around 2130 at night and [client #5 (sic)] mom asked him why he didn't tell her and [client #5] felt that he was being blamed." -"On 7/23/22 about 3 PM, my staff [DSP #11] came to me, [RM #1], and advised me about a sexual assault that not only had taken place on the date mentioned above (7/23/22) but also throughout the year and half. I then spoke to [client #5] and his roommate [client #12]. [Client #5] stated that [client #18] would sneak past staff at busy time in the evenings and go into [clients #5 and #12 (sic)] room. [Client #18] would then attempt to have a			

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	sexual encounter with [client #12] and when [client #12] would tell him no [client #18] would then move over to [client #5 (sic)] bed where he would force [client #5] for oral sex on [client #5] then [client #18] would force anal sex on [client #5]. [Client #12] stated to [RM #1] when interviewed separately from [client #5] the exact same story. I then called the [PM] to let her know of the situation." -"[RM #1] stated that [client #12] has come to staff I believe on the 2nd shift and stated that [client #18] sent me nude photos. [RM #1] states that [client #18] has sent [client #12] text that state "I will suck your [penis]" (this has been recently written up). [RM #1] states that on 7/23/22 [client #12] received a picture of his [penis] to (sic) his phone. [RM #1] stated that on 7/23/22 that once [clients #5 and #12] spoke to me [client #5] went and barricaded himself in his room. [RM #1] states that [client #5] took apart his fan for protection against [client #18]." -"[RM #1] states that she heard several months when [DSP #17] was here that [client #12] was so tired of getting messages from [client #18] (sic)." RM #1's Witness statement form signed and dated 7/25/22 indicated, "I have watched [client #18] on second shift attempt to enter into [clients #5 and #12's] room when [client #18] would apparently think staff was not watching. I have prompted [client #18] multiple times to stay of out of peers rooms and there are no other instances to my knowledge. [Client #5] has also previously stated he didn't feel safe at the facility when I spoke to [client #5] he would never tell me exactly why due to being scared of being seriously			

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	injured by [client #18] as [client #5] stated to us, 'I know what he did to my staff when he stabbed them (sic).'" The review did not indicate documentation of RM #1's statements regarding client #18's attempts to enter clients #5 and #12's bedroom and statements of feeling unsafe due to client #18's physical aggression towards former staff. -"On 7/28/22 [AD (Activity Director)] stated she has never seen [client #18] enter other clients' rooms but she stated he likes to stand at the doorways of them and talks with other consumers. [AD] stated that she has never seen [client #18] enter [client #5's] room at any point. [AD] stated that she has witnessed them hugging in the dayroom before dinner and she stated that she would redirect them. [AD] made a statement that she has heard over the course of a year that [clients #5 and #18] have been dating but never seen (sic) anything between them." -"On 7/28/22 [DSP #16] stated that over her few months work with ResCare never seen (sic) [client #18] enter [client #5] or [client #12] room She stated that she sees [client #3] enter everyone's room as he just runs in and runs right back out. [DSP #16] stated that she has seen [client #18] come out of consumers room (sic) she stated only on Sunday when he was asking where [client #5] was. [DSP #16]stated she is not aware of anyone having any relationships and or any inappropriate touching." DSP #16's Witness statement form was signed and dated on 7/28/22. DSP #16's witness statement form indicated, "Have you ever seen [client #18] go in rooms? No, but I see (sic) him come out. Have you ever seen [client #18] in			

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	[client #5] (sic) room? Yes, on Sunday he said he was looking for him." DSP #16's investigation summary and witness statement were not consistent in documentation regarding client #18's coming out of client bedrooms. -"On 7/28/22, [DSP #2] stated that he has never witnessed any inappropriate touching other than a hug at dinner time on occasion. [DSP #2] stated that he has seen [client #18] enter [clients #5 and #12] (sic) room all the time and when I see him go in, I redirect and he comes right back out. [DSP #2] stated that [client #18] asks all the time how [clients #12 and #5] are if they are not in the building and when they will be back." DSP #2's witness statement form signed and dated 7/28/22 indicated, "Have you ever witnessed [client #18] or [client #5] touch? No, they do give hugs at dinner but that's all. When they hug its for a long period of time I have seen [client #18] enter [clients #5 and #12] (sic) room almost every time I work, When I see him I redirect he doesn't go all the way in (sic). He always wants to know is going on with [clients #5 and #12]." DSP #2's witness statement form dated 7/28/22 indicated the statement was documented by ED via telephone call. The witness form had a written statement by DSP #2 on the back of the page. The written statement indicated, "I have been seeing [client #18] go into [clients #5 and #12's] room to see what's going on in there. I had asked [client #18] what he needed and he states he's just checking something. [Client #18] does it one or so (sic) everyday I work." DSP #2's investigation summary, witness statement and written witness statement forms			

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	were not consistent in documentation of DSP #2's testimony. -"On 7/25/22, [client #5] states that he told staff that [client #18] was being sexual with him. [Client #5] stated that [client #18] was sending pictures and stuff to my phone. [Client #5] stated to staff that he didn't feel safe anymore. [Client #5] states that it was around 2 AM, [client #18] came into my room and got on top of me and whipped out his [penis] and started to masturbate on me. [Client #5] (stated he) then put his penis inside me for about 20 minutes. [Client #5] stated he has told [client #18] no before." -"On 7/25/22, [client #12] stated on Saturday the (7/23/22), [client #12] stated (sic) afternoon at about lunch time [client #18] came into [client #5] and I room (sic) and he jumped on [client #5] and told him to pull his pants down. [Client #18] was in our room for about 30 minutes. [Client #12] states that he was back and forth between being awake and sleep, (sic) [client #12] states that when [client #18] realized I was waking up he jumped up and ran out of the room. [Client #12] states that [client #5] kept yelling "No" but [client #18] doesn't listen to anybody. [Client #18] states nothing happened during the overnight hours leading up to Saturday afternoon. On 7/28/22, [client #12] stated that [client #18] came into our room and I was half asleep and [client #18] came into our room and I was half asleep and [client #18] told [client #5] to pull his pants down and [client #18] sucked [client #5] penis. States that [client #18] wouldn't get off him. It has never happened before. [Client #12] states last time he saw it was a couple of weeks ago. [Client #18] ran into our door and wouldn't let [client #5] out, he wanted to talk to him and [client			

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	#18] were having sex and [client #5] stated to get off me when I walked in (sic). [Client #12] states that he has never seen them in the shower together. [Client #12] states one time he came into his room and [client #5] and [client #18] were having sex and [client #5] stated to get off me when I walked in. [Client #12] states that [client #18] has sent him pictures on his phone and I have attempted to delete them and I can't figure it out. [Client #12] showed [ED] the pictures on his phone. [Client #12] stated that he has heard that [clients #18 and #5] are dating but [client #5] tells me they are not. [Client #12] states sometimes I have run into my bathroom when [client #18] comes in our room and sit on the floor because I was scared. I would hear [client #18] and [client #5] doing things but I have never distracted staff so they could do things." -"On 7/28/22 [client #18] states he doesn't go into anyone's room, I like to stand at the doorways. [Client #18] states that he doesn't touch anyone inappropriately other than [client #5]. [Client #18] states that [client #5] lets me [masturbate him] and [oral sex]. [Client #18] states that we have been together along time before ResCare. [Client #18] states that [client #12] distracts staff so me and [client #5] can [masturbates] each other. [Client #18] states that [client #5] [masturbates] and I sometimes [perform oral sex] because he is my boyfriend. [Client #18] states last time we did it was [client #18] thinks it was Thursday or Friday. [Client #18] states that 3 or 4 months ago I was in the shower and [client #5] came and told me to [perform oral sex]. [Client #18] states he did it while he was on the shower chair. [Client #18] states on Saturday [client #12] was mad cause I wouldn't [masturbate] him off. [Client #18] told [client #12] I couldn't do that I am with [client #5]. [Client #18] states I am bi-sexual. [Client #18]			

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	states [client #12] has sent him videos of girls with big [vagina with explicit description]. [Client #18] stated that sometime [client #12] will stay and watch and he [masturbates] while we are doing stuff." -"[Client #8] states that he has seen [client #18] and [client #7] in the shower before with the door open, they had their clothes on. I have never seen anything else between anyone ion (sic) the building." -"On 7/28/22, [client #14] states that he didn't see anyone go into [clients #12 and #5] room on Saturday 7/23/22. [Client #14] states that in the kitchen a long time ago that [client #18] grabbed his [testicles]. [Client #14] stated [client #18] said if you don't let me touch you then there will be consequences. [Client #14] states he has never done anything since that day but doesn't remember the day on our hallway (colts) but he says [client #18] will go into other client's room on the other hallway (pacer's). [Client #14] states he has never seen [client #18] or [client #5] touch each other at all." -"On 7/28/22, [client #7] states that no one has ever entered his room since he has changed rooms. [Client #7] stated over a year or more that [client #18] touched his penis but that was investigated and nothing has happened since that day. [Client #7] stated he has seen [client #18] enter [client #5] room a few times but he just talks to them and staff get him out when they notice. [Client #7] states that he has never seen [client #18] or any clients dating each other at all." -"On 7/28/22, [client #15] states he has seen [client #18] enter [client #5] room several times and he says he went into his room at 6:30 PM on			

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	Saturday night. [Client #15] states I think he wanted to know if [client #5] was ok cause he wasn't in the building. [Client #15] states he has seen [client #18] touch other clients. [Client #15] states he likes to horseplay with everyone. [Client #15] stated that he sees [client #14] and [client #18] in everyone's rooms and they like to talk to everyone. [Client #15] stated nothing happened on Saturday the 23rd that he remembers." -"Factual Findings 1. [Client #14] states [client #18] has made threats related to sexually acts one time to him. 2. [Client #16] states the [client #18] enters [client #5] room for approximately 60 seconds and others room but nothing has happened. 3. [Client #19] states that [client #18] was seen entering [client #5] room for 2 seconds. 4. [Client #5] first interview (7/25/22) he stated [client #18] sent pictures to his phone, [client #18] masturbated on him, [client #18] had his penis inside of him for 20 minutes and he does not feel safe. 5. [Client #5] second interview (7/28/22) he stated he has never had sex with [client #18], [client #18] performed oral sex on him but they have never had sex. 6. [Client #12] states that while in the room, [client #18] jumped on [client #5] (who) kept yelling no. 7. [Client #18] denies going into anyone's room, he does not touch anyone inappropriately other than [client #5]. [Client #18] stated that he and [client #5] are 'together' and [client #12] distracts staff so that they can [masturbate] each other off. 8. [AD] has heard [clients #5 and #18] are 'together' but has not seen anything occur between them. 9. [DSP #16] has never observed [client #18] enter [client #5] or [client #12] rooms and she is not aware of anyone being in a relationship.			

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	10. [DSP #2] has not observed inappropriate touching and that he does see [client #18] enter [clients #5 and #12] room all the time but he comes right back out. 11. [RM #3] has not observed inappropriate touching and [client #18] enters everyone's bedroom but redirected to exit. 12. [RM #5] has not seen anyone going into other bedrooms at night and has not observed touching other individuals. [RM #5] heard a long time ago that [clients #18 and #5] are together as boyfriends. 13. [DSP #11] has not witnessed inappropriate touching. 14. [RM #2] states that he has not witnessed inappropriate touching. 15. [RM #4] states they position themselves in the hallway so there was no way something could have happened on third shift and she heard 4 months ago that [client #18] and [client #5] were dating. 16. [DSP #4] witnessed [client #18] smack [client #5] on his bottom, hug [client #5] and rub [client #5] private area. 17. [RM #1] stated [client #5] reported that [client #18] forced oral sex and anal sex with him and [client #12] reported the same. 18. Nude photos and sexually suggestive text messages were sent from [client #18] to [client #12] and [client #5]. 19. [Client #18] did not receive enhanced supervision at the time the alleged incident occurred. 20. [Client #5] did not receive enhanced supervision at the time the alleged incident occurred. 21. Camera footage on 7/23/22 revealed the following: -Footage shows at 12:06 PM shows [client #18] touching [client #5] in unwanted touch.			

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	-[Client #18] based off the camera footage does not go into [client #5] and [client #12] room upon [client #5] return from meeting with his guardians. -Based off camera [client #18] does go to [client #5] and [client #12] room but does not go into the room opens the door and shuts. 22. Per [police department detective] this investigation is ongoing. 23. The results of the [client #5] rape forensic examination have not yet been received. 24. Both clients have legal guardians. 25. According BSP [client #12] has target behaviors for telling stories that he will sometimes later recant. He is quick to do this if he feels that it will help him avoid getting into trouble. 26. According to BSP [client #5] has target behaviors for inappropriate sexual behaviors: defined as exposing his genitals to others in public places, touching other's private areas, rubbing himself on others, or making verbalization/gestures of a sexual nature to other in a common area. Also included masturbating in public areas. Includes attempt to remove the clothing of others. False reports/calls to 911: defined as any time he calls 911 and hangs up or any time that he calls 911 to make a false report. 27. According to BSP [client #18] has target behaviors for false reports/making hang up calls with 911: defined as any time he calls 911 and hangs up or any time that he calls 911 to make a false report. Boundary violations: defined as hugging others without permission, rubbing the backs/arms/bodies of others or invading the personal space of others. Included acts of flicking or poking others. [client #18] has demonstrated boundary violations against staff and peers." -"Conclusion 1. It is not substantiated that [client #18] sexually assaulted [client #5].			

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	2. It is substantiated that [client #18] touched [client #18] in an inappropriate manner. 3. It is not substantiated that [client #5] did not consent to sexually acts or to be touched by [client #18]. 4. It is not substantiated that [client #18] supervision level was not followed appropriately by staff. 5. It is not substantiated that [client #5] supervision level was not followed appropriately by staff. 6. It is not substantiated that staff failed to follow ResCare policy and procedure." The Investigation Summary did not include recommendations to prevent recurrence. ED was interviewed on 8/3/22 at 1:18 PM. ED indicated he had completed the Investigation regarding client #5's 7/23/22 allegation of sexual assault. ED indicated the initial allegation was client #18 had raped client #5. ED indicated client #5's recollection of the timeframes of the alleged incident was between 2-3 AM or 12:30 PM on 7/23/22. ED indicated client #5 alleged client #18 entered his room, jumped on him and penetrated his anus while he was telling him no. ED indicated he was not initially aware of the allegation of sexual assault in the shower room. ED indicated the investigation was completed between 7/25/22 and 7/29/22 with the final investigation summary completed 8/2/22 at 3 PM. ED indicated he made recommendations to have client #18 be placed on 1 to 1 staff to client ratio supervision. ED stated he had made the recommendations based on "what I heard during the investigation that it would be one way to include (sic) the safety of the other clients. He's currently on 5-minute checks because of prior elopement." ED indicated his recommendations for 1 to 1 staff to client ratio			

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	supervision for client #18 had not been implemented. ED indicated he would need to follow-up with PM to begin implementation. ED state, "I don't believe he's targeting other clients. I heard of lot of hugging or horseplay but could be redirected. (Recommendation) basing it off of past history." ED stated, "He routinely enters other client bedrooms." ED indicated client #18 should not be in other clients bedroom as a part of ResCare's policy. ED indicated client #18's BSP did specify he should not be in bedrooms of his peer's. ED indicated he reviewed the agency's video monitoring system from 12 AM through 4 PM on 7/23/22. ED indicated he was not aware of any allegations prior to 7/23/22 at 12 AM. ED indicated client #5 had a guardian and would need guardian consent with the IDT to engage/consent to a sexual relationship/activity. ED indicated there was not IDT or guardian consent. ED indicated the investigation included allegations regarding client #18's use of his phone to send clients #5 and #12 explicit pictures and explicit messages. ED indicated he had recommended restrictions on client #18's personal phone. ED indicated there was not documentation of the cell phone restrictions recommendations included the investigation. ED indicated the investigation included factual finding #7. ED indicated factual finding #7 documented client #18's admission of touching client #5 due to being in a relationship. ED indicated the investigation included a conclusion #3. ED indicated conclusion finding #3 documented it was not substantiated client #5 did not consent to sexual acts or to be touched by client #18. ED indicated client #5 should not be dating other clients and did not have guardian and IDT support or approval to consent to being in a sexual relationship or acts. ED indicated he			

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	based the unsubstantiated on the sexual assault aspect. ED indicated the investigation included an interview with DSP #4. ED indicated DSP #4's interview included allegations for the two nights prior to the 7/23/22 allegations. ED indicated he had reviewed the camera for 7/23/22 12 AM through 4 PM. ED indicated he substantiated the facility followed its policy and procedures. ED indicated corrective measures should be developed and implemented to prevent recurrence. QIDP (Qualified Intellectual Disability Professional) was interviewed on 8/3/22 at 11:28 AM. QIDP indicated prior to being reassigned off of the investigation he had begun a review of clients #5 and #18's BSP's, ISP's and daily pro gress notes. QIDP indicated he had completed an interview with client #5 prior to the ED taking over the investigation. QIDP indicated client #5 alleged the incident happened at 2 AM on 7/23/22. QIDP stated, "[Client #5] said that [client #18] just came in his room and got on top of him. Took his penis out and started masturbating on top of him and had intercourse with him. Told him no and he continued." QIDP stated, "[Client #12] alleged the incident happened at 12:30 PM or lunchtime on the 7/23/22. Basically said [client #18] came in their bedroom and had sex with him. [Client #5] repeatedly said no." QIDP indicated client #5 had a guardian and would need guardian consent to engage in a sexually			

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	active relationship or give consent. QIDP indicated client #18's BSP included 5-minute checks in his bedroom and line of sight supervision when outside of his bedroom after the 7/23/22 incident. QIDP stated, "I don't see it in his BSP specifically but would imagine with his history he should not be (in other client's bedrooms)." QIDP indicated client #18 had a cell phone. QIDP indicated client #18's BSP did not include monitoring or supervision of client #18's cell phone or Internet usage related to sending his peer's sexually explicit images. QIDP indicated he had not seen or witnessed any incidents of client #18 violation of boundaries or inappropriate touching his peers. QIDP indicated if client #18 continued to touch his peer's inappropriately with line-of-sight supervision the intervention should be evaluated for effectiveness. RM (Residential Manager) #1 was interviewed on 8/1/22 at 5:17 PM. RM #1 indicated her role included ensuring staff implemented BSP's and ISP goals. RM #1 stated, "[Client #18] has massive behaviors. Around the end of January, he acted out. I'm not sure what set him off 100%, but it was second shift, and he attacked staff with a pen. He stabbed a staff in the chest twice. He bit another staff. He hurts staff. He hurts staff more than anybody. He's the one that bothers me the most if he's upset with a client. I know what			

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	he's capable of, so I worry about that. I can get him to calm down, talking to him. I'll pull him off to a corner. I know the risk of what happened in January. I'll do everything I can to deescalate." RM #1 indicated client #18 was on 5-minutes checks and line of sight when he's not in his room. RM #1 indicated client #18 was not to have contact with client #5. RM #1 indicated on Saturday, 7/23/22 DSP #4 reported to her an allegation of sexual inappropriate behavior by client #18 toward client #5. RM #1 indicated client #5 had reported to DSP #4 an allegation of sexual assault by client #18 while he was in the pacer unit shower the morning of 7/23/22. RM #1 indicated the allegation was on 3rd shift when he got up but was unable to give a specific time. RM #1 stated, "Just before lunch on that Saturday, I was writing some notes in the RM book, [DSP #4] came in and said [client #18 and client #5] had hugged in the day room. [Client #18] had reached down, and I'm not sure which hand, but [client #18] had groped [client #5's] genitals. [Client #5's] parents were visiting. Right before the parents got here, [client #5] stayed pretty mellow. He said he was upset about it. It was right at lunch time, after lunch, everything else transpired where the allegations of rape transpired." RM #1 indicated client #5 reported client #18 had			

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	been sexually assaulting him between a year and half and two years. RM #1 stated, "He said he did not come to us because the staff he thought he could trust let him down." RM #1 stated, "[Client #5] initially reported to [DSP #17] at least over a year ago. [DSP #17] just looked at [client #18] and, not a full on smack, but a little tap on the hand and said don't do it again." RM #1 stated, "Their visit was in the rec room. It was after they (parents) left, that she spoke to me about it. I wasn't aware of anything before the parent visit other than the alleged groping." RM #1 indicated she had received a text message on 7/23/22 at 12:21 PM. RM #1 indicated the text message reported client #18 had smacked client #5 on his buttocks after prompting to not be inappropriate. RM #1 stated, "[Client #18] pulled [client #5] behind staff and tickled and played with his penis. I texted [PM]. She had me put it as client to client IR (Incident Report) where to talk to the client to get their side of the story and ABC (Antecedent Behavior Consequence) track it. It's going on the yellow sheet regardless. That's when I asked [DSP #4] to sit with him to get a statement. [DSP #4] interviewed [client #5]. I interviewed [client #12] on the backside of the office." RM #1 stated, "At that point, I was informed it was a situation with [client #12] as well. [Client #5] told [DSP #4] that			

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	[client #18] came into the room and told [client #12] he needed to leave. [Client #12] said it was after [client #18] had tried to initiate sexual contact with [client #12]. [Client #18] left [client #12] and went to [client #12's] bed. It was reported [client #12] was asleep. [Client #12] told me [client #18] woke [client #5] up with oral sex. That's when [client #12] was told to leave the room." RM #1 stated, "The time frame, usually 2nd shift does green books around 10 PM to around the beginning of third shift. There are times at shift change, it is kind of chaotic. [Client #18] just slides through the crowd and goes right down to the room."RM #1 stated, "[Client #18] is not allowed to be in other people's rooms, absolutely not. In the hallway, he can talk to someone, as long as someone is watching to make sure he doesn't go in there. I try to keep interaction in the day room only."RM #1 stated, "[Client #5's] made numerous comments about not being safe. They've been written up. He'll go down to the end of Pacer hall and will cry for a few minutes. He'll say I don't feel safe. He'll never say why. He'll say he wants to leave."RM #1 stated, "It was reported to me by [client #14] (that) [client #18] was bragging about thinking how he wants to rape multiple clients. [Clients #9, #21, #11 and #7]. There was a previous incident, a little over a year			

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	ago. [Client #7] and [client #11] were allowed to be in [client #18's] room with [client #5]. I took the report the next day when I got to work. [Client #7] was terrified. He was across the hall from [client #18]. He alleged [client #18] claimed he was going to rape him if he told anyone what was said and done in that room that night. I reported to my RM (former staff). He didn't report it. [DSP #17] was on shift that night and told them they could all be in [client #18's] room together." RM #1 stated, "[Client #18] likes to hug a lot. He'll walk up to anyone and put his arms around them. A few days prior to this report to [PM], [DSP #19] reported to me, before he got there, about 2 am, whatever day it was. A fire alarm went off. It wasn't a planned fire drill. On the walk back over, [DSP #18] was holding the door open for the guys to go back in the building. [Client #18] was holding [client #1's] hand and walked into his room with him. I reached out to [PM] and let her know what was going on."DSP #3 was interviewed on 8/2/22 at 11:27 AM. DSP #3 indicated she had worked at the facility since 2019 and had transferred to a waiver home after client #5's allegations regarding client #18. DSP #3 indicated she continued working with client #5 as a waiver staff while client #5 participated in programming activities at the facility. DSP			

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	15G811	A. BUILDING 00 B. WING	08/09/2022

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	#3 stated, "He didn't say anything to me, I've just heard what's going around. The first story I heard was him and [client #18] were boyfriends. Then he said [client #18] raped him. I wasn't here when it happened."When asked if client #5 was able to give consent or vulnerable, DSP #3 stated, "Yeah, I think he is. I know [client #5] pretty good. When he's upset, it's usually about his family. He's very sensitive. I don't know if he fully understands." DSP #3 indicated client #18 was on 15-minute checks but she was unsure if this was continued. DSP #3 indicated client #18 was on line of sight supervision. DSP #3 stated, "Sometimes we're shorthanded, and it's hard. When you have a 1:1, it's hard to do." DSP #3 indicated client #4 was a 1:1 and client #3 was on line of sight supervision. DSP #3 indicated client #18 utilized the bathroom in the hallway and not the shared bathroom in his bedroom. DSP #3 stated, "[Client #18's] not supposed to be in other clients' rooms. I've caught him. Maybe 3 weeks ago I caught him trying to go into [client #12's] bedroom. No one is supposed to go in anyone's bedrooms." DSP #3 stated, "I've heard he's threatened others, but I don't know. I heard he was going to go after [client #14], sexually. Some of the lower functioning guys (like) [client #3] who can't talk, [client #17], [client #4]. They're in his			

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	hall."When asked if clients #3, #4 and #17 were safe, DSP #3 stated, "If they were in a different hall. [Client #18] is in the same hall, if they were in a separate hall, I would feel more comfortable. In my opinion, they're not safe."LPN (Licensed Practical Nurse) #2 was interviewed on 8/2/22 at 2:54 PM. LPN #2 stated today the unit was "Very loud, unorganized. I can hear it. They have asked for help before. They didn't today. Today was chaotic. One of the most chaotic I've ever seen here. I've been here 6 years." LPN #2 stated, "I've never seen [client #4] so hyper. A lot of times when new people are in the building, clients are attention seeking more. I feel like [client #3] needs to be a 1:1. Staff are overwhelmed with trying to keep an eye on him. He's in and out of everyone's rooms. He could be eating something he shouldn't be eating. He doesn't have any safety. He's not safe. I think that's a lot of the chaos." LPN #2 stated, "The clients all feed off of it. Then we had a staff lose his temper and was screaming. He raised his voice. I came out of the nurses station. It happened again. I heard [RN (Registered Nurse), and I heard screaming in the background."Confidential Interview A stated, "I don't understand why [client #18's] still here. I don't understand what we can do for him. He's stabbed a staff. He's broken a staff's arm. He's accused staff of			

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	misconduct. He has all kinds of allegations, sexual stuff." Confidential Interview A stated, "[Client #18's] known for stealing. He was on a rampage saying he was going to get staff fired. He's been here a long time. I don't feel like we're helping him at all. He'll go for a long time and be fine, then he snaps. He bit a tattoo off the staff's arm. Another girl has a huge scar where he had bit her, too. I'm scared to death to be by myself with him."Confidential Interview A stated, "I don't feel like anyone is safe around him."Observations were conducted at the facility on 8/2/22 from 11:58 AM through 1:00 PM. At 11:58 AM, clients #6, #16, #18 and #19 were seated at a table in the dining room area. Client #10 was seated at a table next to client #18. The dining room area and dayroom area were the same open space. The unit was loud with constant movement of staff and clients between the dayroom, dining area and kitchen. The noise level was loud. Client #3 was constantly pacing the dayroom, hallways, entering client bedrooms and the dining room area. Client #4 was engaged in behavior throughout the observation attempting self-harm, loud yelling and staff redirection. At 12:10 PM, client #18 encouraged clients #6 and #19 to hold hands while seated at the table across from him. Client #6 held client #19's hand, placed his hand up to his facial area, kissed			

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	his hand and caresses his hand while client #18 encouraged the behavior and laughed. At 12:17 PM, client #18 was seated directly across the dining room table from client #6. Client #18 held client #6's hands with both of his hands while stroking and pulling on client #6's fingers. Staff working in the area were engaged in meal preparation and managing client #3 and #4's behavior. No staff redirected client #18. At 12:23 PM, client #8 stood up from the dining room table and used his hands to cover both of his ears. Client #8 then walked out of the dining room to his bedroom with his hands covering his ears. At 12:40 PM, client #18 turned to his right side where client #10 was seated. Client #18 rubbed client #10's back and then held client #10's left hand. No staff redirected client #18. Client #8 was interviewed on 8/2/22 at 12:35 PM. Client #8 indicated the dining room was loud. Client #8 indicated he did not like the loud noise level and covered his ears. Client #5's record was reviewed on 8/4/22 at 3:07 PM. Client #5's CFA (Comprehensive Functional Assessment) dated 10/18/21 included a Human Development Section and indicated the following:-"15. Expresses understanding of an orgasm. No.16. Expresses interest in developing a sexual relationship. No.17. Expresses interest in learning more about social/sexual behavior their body, feelings,			

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	etc. (sic). No."-"19. Expresses sexual attraction. No.20. Has a girlfriend/boyfriend/serious partner. No."-"24. Says 'No' to unwanted sexual advances. Yes."-"26. Calls for help when bothered. Yes.27. Approaches others for sex or touch. No.28. Expresses interest in dating. No."Client #18's record was reviewed on 8/4/22 at 3:55 PM. Client #18's BSP dated 7/13/22 indicated the following:-"Inappropriate Sexual Behaviors: defined as exposing his genitals to others in public places, touching others' private areas, rubbing himself on others, or making verbalizations/gestures of a sexual nature to others in a common area. Also includes masturbating in public areas. Historical documentation indicates that [client #18] tends to look for opportunities to sexually act out with his peers. He has followed peers into the restroom or into their bedrooms in the past."-"Boundary Violations: defined as hugging others without permission, rubbing the backs/arms/bodies of others or invading the personal space of others. Includes acts of tickling or poking others. [Client #18] has demonstrated boundary violations against both staff and peers."-"He will have 15-minute checks while inside the residential building."-"[Client #18] will not be in the bedrooms or doorways of his peer's rooms (target			

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	behavior: theft, sexually inappropriate behaviors)."-"There will be a lock on the pass-through bathroom so that [client #18] cannot enter his peer's bedroom through the shared bathroom (target behavior: theft, sexually inappropriate behaviors)."Client #18's BSP revised date 7/27/22 indicated the following:-"Due to sexually inappropriate behaviors with peers, [client #18] will remain in line of sight whenever he is out of his bedroom, including outside. He will have 5 minute checks while in his bedroom."-"Due to sexually inappropriate behaviors with peers, [client #18] will not have access to his shared bathroom and he will use the hallway bathroom. Staff must check the bathroom prior to [client #18] entering to make sure no other peer is in the restroom."Client #18's IDT note dated 7/26/22 indicated the following:-"On July 23, 2022, at 3 PM, [client #5] reported to staff that he allegedly had been sexually assaulted by [client #18]. [Client #5] was transported to [first emergency room] for an examination then transferred to [second emergency room] due to not having a sex assault examiner on shift. While at [first emergency room] [client #5] and staff both gave statements to the [police] and a police report was filed. The forensic rape examination was performed and [client #5] was released from the hospital."-"Recommendations: Discussed 1			

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	to 1 staff to client ratio and meeting with [counselor] on 8/2/22 due to previous request and due to increase in sexual preoccupation."-"[Client #18] will not have access to his bedroom's shared bathroom and will use the hallway bathroom at this time." Client #5's BSP (Behavior Support Plan) dated 7/20/22 indicated the following: -"His mother is [guardian] and she has recently become [client #5's] guardian."-"Staff are to be within earshot of the door when [client #5] is in the shower in case he calls out for help as he has a history of seizures that result in falls. Staff should pay attention to potential sounds of a fall or seizure activity."The review indicated client #5 had a target behavior of false reporting emergencies to 911. The review did not indicate documentation of false reporting of allegations of abuse, neglect or mistreatment. The review indicated client #5 had a legal guardian. Client #5's IDT (Interdisciplinary Team) form dated 7/26/22 indicated the following:-"On July 23, 2022, at 12:06 PM, while in the dayroom peer smack [client #5] on his buttocks; peer was verbally redirected and educated on boundaries. Peer then walked behind staff and then hugged [client #5] and then touched the outer part of the pants on his groin area. Peer was educated on personal space and redirected to another area. On July 23,			

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	2022, at 3 PM, [client #5] reported to staff that he allegedly had been sexually assaulted by [client #18]. [Client #5] was transported to [first emergency room] for an examination then transferred to [second emergency room] due to not having a sex assault examiner on shift. While at [first emergency room] [client #5] and staff both gave statements to the [police] and a police report was filed. The forensic rape examination was performed and [client #5] was released from the hospital."-"[Client #5] has been offered emotional support. [Client #5] with team/guardian approval has been moved to a different building. [Client #5] and [client #18] will remain separated until further notice. [Client #5] will receive one on one staff supports while staying in alternative building. [Client #18] will receive 5-minute checks while in his bedroom and line of sight when out of his bedroom. [Client #18] does not have a roommate. Both individuals are scheduled to meet with the detective separately on 07/25/22 to provide further statements. ResCare will cooperate with the [police department's] investigation. ResCare has also initiated an investigation. The administration team including Executive Director were notified. IDT team meeting to be held for both individuals to discuss further protective and preventative measures."PM (Program Manager) was interviewed on			

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	8/3/22 at 10:32 AM. PM indicated RM #1 called and reported an allegation of sexual assault on 7/23/22 regarding clients #5 and #18. PM indicated she called and spoke with client #5. PM indicated client #5 returned from a family visit and reported client #18 had assaulted him. PM indicated client #5 had not reported the allegation to his family during the visit. PM indicated client #5 reported the allegation to a detective while at the hospital. PM indicated client #5 reported to the detective client #18 had come in his room and had anal sex with him. PM indicated client #5 reported this happened more than once and client #5 told client #18 to stop. PM indicated client #18 denied the allegations but did make statements about masturbating with client #5 while client #12 watched for staff. PM indicated client #5 was afraid of client #18. PM indicated client #5 had a guardian and would need consent to participate in a sexual relationship. PM indicated there was not an assessment, guardian or IDT review and consent available for review regarding client #5's ability to consent to sexual relationships. PM indicated client #18 was placed on 5-minute checks while in his room and on line of sight supervision while outside of his room. PM indicated line of sight meant to monitor and redirect client #18's behaviors. PM indicated client #18's boundary			

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	violations and touching his peer's should be redirected and documented as target behavior. BC was interviewed on 8/3/22 at 12:42 PM. BC indicated client #18's BSP was updated to include 5-minute checks while in his bedroom and line of sight supervision while outside of his bedroom. BC indicated client #18 would use the common shower and restroom and his bedroom shared restroom would be restricted. BC indicated client 18's line of sight supervision was assigned by the RM at the beginning of the shift. When asked if line of sight was an effective intervention for client #18, BC stated, "Depends on the staff implementing it. [Client #18] is very clever.]" BC indicated the IDT had discussed making client #18 a 1 to 1 staff to client ratio supervision to prevent targeting other clients. BC indicated 1:1 supervision had not been implemented.This deficiency was cited on 6/9/22. The facility failed to implement a systemic plan of correction to prevent reoccurrence. 5-1.2(24)(l)			
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 individual program plan.			

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	Based on observation, record review, and interview for 1 of 4 sample clients (#3), plus 5 additional clients (#9, #13, #19, #20 and #21), the facility failed to ensure clients #3, #9, #13, #19, #20, and #21's active treatment programs were implemented during formal and informal training opportunities. Findings include: 1. An observation was conducted in the facility on 8/2/22 from 12:00 pm until 1:15 pm. Client #13 was present in the facility throughout the observation period. On 8/2/22 at 12:30 pm, client #13 was seated at a dining table with Direct Support Professional (DSP) #9 sitting next to him as client #13's assigned 1 to 1 staff. DSP #9 stated, "You peed, let's go change. You're wet." DSP #9 prompted client #13 to go to his bedroom. There was a puddle of urine under client #13's chair, and his pants were visibly wet. Client #13 stood up and began hitting himself in the head and biting his hands. DSP #9 again prompted client #13 to his bedroom. At 12:35 pm, client #13 and DSP #9 were standing in client #13's bedroom (shared with client #3). Behavior Clinician (BC) went into client #13's bedroom. Client #13 was hitting himself in the head with the heel of his hand and was biting his hands. DSP #9 stated, "No, stop." BC stated, "I can't have him keep hitting himself." Client #13 sat on his bed, and DSP #9 sat down next to him. DSP #9 and BC put client #13 in a two person sitting hold on the edge of client #13's bed. DSP #9 stated, "You're not biting me bro." BC stated, "Let's be reassuring." BC stated to client #13, "Let's calm down, so we can go for a walk." Client #3 came into the bedroom, wrapped himself in a	W 0249	**W 249** **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, all facility direct support staff will be retrained regarding: ·Proper implementation of all clients' prioritized learning objectives and target behavior interventions and the need to provide continuous skills training at formal and informal opportunities. ·Proper implementation of clients' Comprehensive High-risk Plans. **PREVENTION:** For the next 30 days, members of the Operations Team will conduct daily administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including weekend observations. After 30 days, administrative monitoring will occur no less than three times weekly until all staff	08/29/2022

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	blanket, and began rolling on his bed. BC stated, "We're going to need another person." DSP #9 stated, "There's no one else here." Client #13 remained in a two person sitting hold on the side of his bed. While in the hold, client #13 put his hands to his mouth and bit his hands and arms. Client #13 attempted to bite staff and scratched them with his finger nails. BC stated, "If he's sucking, it's fine. If he's biting...." DSP #9 interrupted and stated to client #13, "Really, again? Now I have to write you up again." BC stated, "Don't talk like that, [DSP #9]." DSP #9 stated, "I have to." BC stated, "I understand, but he doesn't need to know that." Qualified Intellectual Disabilities Professional (QIDP) walked past the room and looked in through the open door. BC stated, "Can you get another staff?" DSP #9 stated, "There are no staff. There's only 4 of us here." Residential Manager (RM) #1 walked into the room. RM #1 took BC's place sitting next to client #13. RM #1 and DSP #9 sat on each side of client #13 with their inside arms wrapped under his biceps and over his forearms. They used their outside arms to hold his wrists down. RM #1 asked what happened. DSP #9 stated, "He peed, and I tried to get him into his room. He didn't want to be in here." Client #13 bit RM #1 on the shoulder. RM #1 stated, "Oh, easy. No biting. It's one thing to scratch, but please don't bite." Client #13 continued scratching DSP #9 and RM #1's hands and attempting to bite them. BC held client #13's legs down. At 12:45 pm, RM #1 used her radio to call for a nurse. Client #13 pulled his right arm free from RM #1 and grabbed her left breast. Client #13 squeezed and twisted. RM #1 placed client #13's arm back into the hold. DSP #9's hand was visibly bleeding. At 12:47 pm, RM #1 used her radio to call for		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. Current Operations Team members received training from the Operations Support Specialist to assure a clear understanding of administrative monitoring as defined below. · 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 **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Direct Support Staff, Operations Team, Regional Director, Operations Support Specialist **CORRECTIONS COMPLETED**	

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	assistance to client #13's bedroom. BC recommended client #13 be placed in a supine hold. DSP #9 stated, "We can't because of his strokes. He can't be on his back. BC stated, "This isn't working. He's getting more agitated." At 12:48 pm, client #4 walked into client #13's bedroom and got on client #13's bed. DSP #9 stated, "Where is the nurse? What is she doing?" Licensed Practical Nurse (LPN) #2 came into the room with a syringe and needle and got onto client #13's bed behind client #13. QIDP came into the room and watched. RMs #4 and #6 came into the room. LPN #2 stated, "[Client #4] can't be in here. It's privacy." QIDP, RM #4 and RM #6 prompted client #4 to leave the room and left with him. LPN #2 gave client #13 a shot and indicated it was 5 milligrams (mg) of Haldol (anti-psychotic). At 12:50 pm, RM #2 entered the room and LPN #2 asked him to get an [adhesive bandage]. LPN #2 asked what happened and BC stated, "He's biting himself, hitting himself, biting them." LPN #2 stated, "It's more chaos out there than I've ever seen in my life." Client #13 put his face next to DSP #9's arm. DSP #9 stated, "Go for it, bud." BC stated, "[DSP #9], I know you're frustrated. Control, please." Client #13 continued attempting to bite staff. Client #13 sat still with DSP #9 and RM #1 holding him in a sitting hold. BC was on the bed behind client #13, on her knees, holding blocking pillows between client #13 and staff. RM #1 began tickling client #13. RM #1 stated, "Oh, that was a little ticklish. He's adorable when he starts laughing." At 12:58 pm, client #13 was released from the hold. DSP #9 stated, "I need gloves." RM #1 directed DSP #9 to gloves. DSP #9 stated, "Those do not fit my hands. I don't know what is wrong with you guys." DSP #9 left client #13's bedroom. RM #2 walked into client #13's bedroom and took him into his attached bathroom. RM #2 indicated he		**BY:** 08/29/22	

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	wanted client #13 to change his clothes. Client #13 attacked RM #2. RM #2 held client #13's arms from behind and escorted him back to his bed. RM #2 and RM #1 put client #13 back into a sitting hold on client #13's bed. DSP #9 was on the floor, holding client #13's legs. Client #13 was spitting and attempting to bite. DSP #9 stated, "I swear to God." Activity Director (AD) replaced DSP #9 in the hold. RM #4 came into the room. QIDP, client #4 and client #12 were standing in the doorway watching. RM #1 prompted them to leave. QIDP closed the bedroom door. Client #3 came into the room and got on his bed. Client #3 left the door open. Client #2 came to the doorway and was watching client #13. RM #1 prompted client #2 to go away. Client #2 continued watching client #13 from the open doorway. DSP #9 walked up to client #2 and put his face in front of client #2's face. Client #2 and DSP #9 grabbed one another's forearms and stared at one another. DSP #9 stated, "Go." Client #2 turned around and left the room. At 1:02 pm, client #13 was lying on his back on his bed with his feet on the floor. BC was behind client #13 on his bed attempting to block his bites. RM #2 was seated next to client #13 on his left side, RM #1 was on client #13's right side, AD had one hand on each of client #13's hips and was pinning him to the bed, RM #4 was holding client #13's feet down. At 1:03 pm, client #4 entered the room. QIDP followed him 15 seconds later and prompted him to leave. Client #4 went into the bathroom. QIDP shut the bathroom door. QIDP watched the hold while client #4 was in the bathroom with the door shut. Client #4 came out of the bathroom. At 1:06 pm, QIDP and client #4 left the room. At 1:07 pm, RM #2 began playing music on his phone. There was discussion of whether client #13 liked music. Over the radio, administration			

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	was called to the main floor of the facility. At 1:08 pm, client #3 came into the room, wrapped himself in a blanket, and laid down on his bed. At 1:10 pm, LPN #2 prompted client #3 to leave the room. At 1:15 pm, client #13 was still on his back in his bed with 5 staff holding him down. Client #13 continued attempting to bite and scratch staff. On the radio, there was a call for assistance in the day room stating, "We have a major problem. Staff is over the top." Screaming could be heard from the day room. Staff released client #13 from his hold. RM #2 prompted client #13 to put on shoes and took him outside for a walk. Client #13's record was reviewed on 8/3/22 at 10:01 am. Client #13's Behavior Support Plan (BSP) dated 7/18/22 indicated the following: "[Client #13] [identifying information] who transitioned to ResCare in [town] on 7/1/22.... [Client #13] has an extensive medical history including a stoke in 2005 and exposure to drugs and alcohol while in utero. He is non-verbal and struggles to appropriately tell staff what he wants and needs. He does know some sign language, but he will often choose not to communicate in this way. He requires hand over hand assistance and verbal prompting for most tasks including hygiene. [Client #13] is not toilet trained, and he wears an adult pull up. [Client #13] is diagnosed with PICA which means he persistently tries to eat non-food items that have no nutritional value (paint, dirt, etc). Additionally, he has an extensive history of 'gumming/biting' his hands, and this has resulted in scarring.... After arriving at ResCare, [client #13] began to demonstrate the behaviors of checking/sucking on his hands in a non-self-injury manner. Additionally, he demonstrated the behavior of			

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	drinking his own urine. These two behaviors were added as target behaviors in this plan. Target Behaviors and Goals: Verbal Aggression: Any time he is yelling at others, cursing, screaming, etc.... Self-Injurious Behavior: Hitting self, banging one's own head into a door/corner/hard object, cutting self, pinching himself, and other behaviors intentionally done to harm/hurt one's self. A helmet was ordered for [client #13] at his previous placement, but he was not compliant with wearing it. He has a history of biting his wrists/hands and fingers, and he will also lightly chew on his hands.... Physical Aggression: Any occurrence or attempts at hitting people, spitting on them, kicking or scratching at others, using objects as weapons, pulling hair, or behaviors that produce or have the potential to produce an injury to others.... Non-Compliance: Any time he is not engaging in programmatic requests (e.g. maintaining hygiene, dietary recommendations, etc), within three verbal prompts spaced out at least 15 minutes apart (when appropriate).... Hand/Wrist Chewing: Any time he is lightly chewing or sucking on his wrist or hand.... Supervision: - 1:1 approximately arms reach staff supervision when awake due to an extensive history of PICA and elopement. When he is asleep, he will have 5 minute checks.... - [Client #13] will be prompted on an hourly basis to use the restroom due to a history of enuresis (involuntary urination).... - Wrist/hand guards will be provided for [client #13] due to his extensive history of checking and sucking on his hands. PRN (as needed) Protocol: In 'crisis situations' (a 'crisis situation' is defined as any situation where the client continues to			

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	behave dangerously.... When prevention techniques, de-escalation procedures, replacement behaviors, and coping skills have been implemented and have failed to avert the dangerous behavior, and the consumer has shown the inability to make choices that are in the best interest of his own health and safety, restrictive behavioral controls may be utilized by staff. The use of PRN medication is viewed as the most restrictive measure and will only be used after less restrictive measures have been attempted and failed to avert the crisis. - Nursing staff will complete an assessment to determine the need for a PRN medication when observing [client #13] to be engaging in target behaviors without demonstrating the ability to calm and after less restrictive measures have been attempted and failed to avert the crisis.... Preventative Procedures: - Keep [client #13] engaged with activity, walks, or other tasks to avoid boredom. - [Client #13] responds well to high fives, pats on the back, and back rubs when staff want to show him praise. - If [client #13] is trying to communicate with staff, ask him to show you what he wants.... - Speak to him a calm, neutral-toned voice at all times. - Do not take any verbal aggression or physical aggression (or any target behavior) personally.... - When giving him instructions/requests, they should be: Given in a clear and concise manner/one step at a time. Done in the form of a question and not a demand.... Reactive Procedures: ... For Physical Aggression/Property Destruction: - Immediately ensure the health and safety of everybody in the immediate environment. Redirect him and/or others to a different area of the environment.			

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	- Tell him to stop the behavior. - If he stops the behavior, redirect him to a safe location and problem solve with him and praise him for doing this with us. - If the behavior continues, block all attempts of aggression and attempt to redirect, if the behavior continues, and he is placing himself or others in danger, implement You're Safe I'm Safe (YSIS) (psychical redirection and restraints) beginning with the least restrictive measures. One person YSIS. Two person YSIS. Two person supine restraint. - Once he is calm, thank him for calming down. - Notify administration staff and document on all appropriate forms.... For Self Harm: - Immediately ensure his safety by blocking or removing the item he is using to harm himself with. - If he is head banging, utilize a head mat under his head. Redirect him and/or others to a different area of the environment. - If he stops the behavior redirect him to a safe location and problem solve with him and praise him for doing this with us. - If the behavior continues, block all attempts of self-harm and attempt to redirect, if the behavior continues, and he is placing himself or others in danger, implement You're Safe, I'm Safe (YSIS) beginning with the least restrictive measures. One person YSIS. Two person YSIS. Two person supine restraint. - Once he is calm, thank him for calming down and let him know if there is anything he needs to come to staff, and we will help him problem solve. - Notify administration staff and document on all appropriate forms.... For Non-Compliance: - Let him know the importance of complying with our request. We are trying to help him reach his			

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	personal goals, etc. - Do not say anything about the request for at least 15 minutes (when appropriate). Repeat the request and provide the rationale for him to follow through with the request, but do not say anything else about the request. Once he has been prompted three (3) times, spaced out at least 15 minutes apart, and he has not complied with the request, document the incident and move on with the rest of the day. If the request is related to anything on the MAR (medication administration record), inform the nurse after three requests spaced at least 15 minutes apart. - If the request is something that has to be completed, notify the Q (Qualified Intellectual Disabilities Professional [QIDP]) after the second request to determine a plan of action. - If at any time he complies with the request, give him abundant praise and move on with the day.... For Hand/Wrist Chewing: - Verbally prompt [client #13] to use one of his sensory chews and assist him with putting on his wrist guards (if tolerated). - Provide [client #13] with an activity or walk after he has complied with using/taking the chews and wrist guards. - If [client #13] refuses his wrist guards and sensory chew, document ABC (antecedent, behavior, consequence) tracking. - If soft hand/wrist chewing is leaving marks/injury on [client #13], follow the reactive procedures for self-injurious behaviors. - Notify administration staff and document on all appropriate forms. Be sure to document what triggered this behavior.... You're Safe, I'm Safe Summary of Techniques: Listed in order of least restrictive to most restrictive. Basic Moves Personal Space/Prepared Stance: Maintain visual			

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	1 1/2 arm's length away, feet shoulder width apart and body at 45 degree angle, hands in non-threatening position, non-threatening tone of voice. Blocking aggression or swinging objects: from prepared stance, raise both arms parallel to each other and sweep in the direction of the blow with your outside forearms, resume prepared stance. Physical Redirection: from behind the individual, pin individual's arms between elbow and shoulder with your forearms, tuck head or lean back to avoid head butts, lock hips, move the person to a safe area, release hold, resume prepared stance.... Bites: don't pull away, anchor the individual's head and press the body part being bitten into the person's mouth, press down while rolling out away from the person, resume prepared stance.... Advanced Moves One Person Standing Restraint/Escort: approach from rear, slide one arm across the back to grasp the person's furthest forearm in an overhand grip, lock hips, reach across your own body to grasp the person's forearm in an underhand grip; (sic) can escort the person to safety or away from a reinforcing situation. Two Person Standing Restraint/Escort: one staff approach from each side with one taking the leading role, reach across the individual's back to grasp the individual's outside forearm using an overhand grip, reach across your own body to grasp the individual's wrist closest to you with an underhand grip. (Staff may instead grab the individual's forearm with outside hand and grab their own forearm with their inside hand). Hips should be snug for stability. Draw the person's elbow backward and secure snugly over your hip; can escort the person to safety or away from a reinforcing situation. If the person attempts to fall, go down on the closer knee while maintaining arm position.			

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	Two Person Seated Restraint: one staff approach from each side with one taking the leading role, reach across the individual's back to grasp the individual's outside forearm using an overhand grip, reach across your own body to grasp the individual's wrist closest to you with an underhand grip. Hips should be snug for stability. Draw the person's elbow backward and secure snugly over your hip. Keep head tucked or away to avoid bites/head-butts. Two Person Lift: use a lifting belt if possible, use the same hold as the two person standing/seated restraint, keep inside knee down and outside knee up, count to 3 and lift together at a 45 degree angle." Behavior Clinician (BC) was interviewed on 8/3/22 at 1:07 pm and stated, "While [client #13] was eating, I was asking [DSP #9] what kind of sensory chews [client #13] likes. [DSP #9] said he didn't know. When I walked away, everything was good. Based on the nature of non-compliance, if [client #13] soiled himself at the meal, I can see [DSP #9] thinking it needs to be done and come back to the meal. I assume [DSP #9] was thinking it was a dignity or a hygiene issue, and he needed to get him to change and come back to the meal." BC stated, "From what I saw, they kept saying, 'We don't have anybody to help.' The staff was not helping the situation with their frustration. I had to redirect [DSP #9] from the statements. He was making it worse. I get that it hurts, but he was doing it to both of us. He went over the line and was taking it personally." BC stated, "There's nothing in the plans to indicate a supine should not be done. I said we need to do a supine, and staff said we couldn't because of the strokes. I was gone, and I was thinking, 'Did he have a stroke over the weekend I			

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	don't know about?' The nurse had shared a nursing note from a previous placement where a nurse had recommended not to use a supine. That's where it came from. There's nowhere it says in his current BSP we're not using a supine for him." BC stated, "[Client #13] is just at 30 days. He hasn't been in a hold yet. When I'm tracking behaviors, I'm tracking 2 person escort. We've never seen that. We've not even had a document of SIB. It's mostly been a 2 person escort. I know there's been more than one 2 person sitting hold." BC stated, "What happened [8/2/22], that can never happen again. We need to figure out what we will do in that situation. The SIB we have not seen before. I was even questioning why the previous facility had purchased a helmet. We haven't seen that." BC stated, "The hold he was in isn't in his plan. It should have been a 3 person supine. They were getting bitten left and right and scratched the entire duration of that hold. It wasn't effective." BC stated, "The first day he was here, [client #13] wore the wrist guards. They kind of go up to his shoulder. We just need it on his hands. [Nurse Manager] was going to order wrist guards. We've asked for approval for those. I don't know if he was using any sort of sensory chew or anything like that. He has communication cards here. There are 2 sets in his room. We're going to use that visual route if that'll work." BC stated, "When we let him up the first time, I think at that point, we thought we were through it, and he would be willing to change at that point. It seemed like it was immediately back to the self-injury. Then he went after [RM #2] in the bathroom with physical aggression, and he went back into the hold. He's someone I would gear the plan to not sit in the supine with this client. When we let him up the second time, he was			

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	done. I wasn't even afraid to walk past him. The hold isn't an effective intervention for him. It's not calming for him. It was creating more fear. He's not going to deep breaths with you or get tired and want to be done with it. I don't think a supine, at least not the hold he was in, will be effective in calming him. He almost needs to be released right away." BC stated, "That hold was a mess." BC stated, "I think verbal abuse occurred when [DSP #9] growled at [client #13]. I did report that to [Regional Director] and [Nurse Manager]. He didn't finish his sentence but he said something like, 'Oh, bite me again. Do it again.' We don't need to meet the level of aggression that was there with our tone. He said, 'Oh, I'm gonna.' I told them I was concerned about [DSP #9]. If nothing else he needs some one on one how we address these clients and manage being hurt." 2. Observations were conducted in the facility on 8/1/22 from 1:10 pm through 2:45 pm, from 4:20 pm through 6:55 pm, and on 8/2/22 from 7:15 am through 9:00 am. At 2:15 pm the Qualified Intellectual Disabilities Professional (QIDP) was with client #3. Client #3 galloped quickly down one hallway. The QIDP redirected client #3 out of client 4's room. The QIDP redirected client #3 out of client #6's room. At 2:18 pm, client #3 drank a cup of juice that was on the table. Client #9 said loudly "Hey, that's my juice." The Qualified Intellectual Disabilities Professional (QIDP) did not take the cup away from client #3 and allowed him to finish drinking from client #9's cup. At 2:22 pm, client #3 quickly galloped down the opposite hallway and entered client #2's room. Client #3 came out of the room chewing on an item in his mouth. Client #3 galloped to the day room and then down the other hallway and into client #21's and then client #4's room. At 2:26 pm client #3 went into client #21's room. At 2:38 pm client #3			

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	continued to chew what he had in his mouth from client #2's room. Direct Support Professional (DSP) #9 was one on one with client #3 and stated "I can't chase him down the hallway, there's not enough staff to stay in the day room." At 2:42 pm, client #3 returned to the day room. Throughout this observation, client #3 was not prompted to participate in a motor skills activity with staff per his plan. At 5:00 pm, client #3 quickly galloped to client #20's room, opened the door and went in. Residential Manager (RM) #1 redirected client #3 out of client #20's room and stated to staff "Just warning you guys, that did not make him (client #20) happy, he is territorial and does not like people going in to his room. It can make him violent." At 5:16 pm, DSP #9 prompted client #3 to stay off of the hallway where client #20 resides. Client #3 proceeded to gallop down that hallway and went into client #7's room and client #12's room. DSP #9 radioed nursing staff and asked if client #3's tablet was in the nurses station to which LPN #4 indicated that it was not. DSP #9 prompted client #3 to his room stating "Let's go to your room and look for your tablet. I can't find it." At 6:05 pm, client #3 went in to client #12's room. Client #12 stated to RM #1 "He won't quit coming into my room." At 6:09 pm, client #3 then again went in to client #20's room. Client #3 crossed the hall and went into client #2's room. When client #3 came out of client #3's room, he had something in his mouth and was chewing it and some type of food items in his hand. Client #3 returned to the day room and DSP #7 took the food items out of client #3's hand and crumbs landed on the floor. Client #3 then bent over and grabbed the crumbs off the floor, put them in his mouth and ate them. Throughout this observation, client #3 was not prompted to participate in a motor skills activity			

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	with staff. Client #3's record was reviewed on 8/8/22 at 11:00am. Client #3's Individual Support Plan (ISP) dated 9/27/21 indicated in part, "Diagnosis: Autism Spectrum Disorder, ADHD Combined Type, Intellectual Disability, Insomnia, Allergies, Constipation. INDIVIDUAL PROFILE & SOCIAL HISTORY: ...[Client #3] is non-verbal and is unable to communicate his wants and needs to others. Previous attempts at using a communication board and picture communication have not been helpful for [client #3]. That said, previous providers indicate that [client #3] can be tech savvy and he enjoys looking at YouTube videos. He is high energy and likes to be on the go and he can get bored easily which often leads to behaviors. In his previous placement, [client #3] had 2:1 staffing due to requiring support during most activities. [Client #3] engages in purposeful regurgitation and he is incontinent of the bowel and bladder. He wears incontinence undergarments but will sometimes take these off. Family and previous providers have had difficulty implementing a toileting plan for [client #3]. Target behaviors have included verbal aggression, physical aggression, property destruction, self-injury, non-compliance, sexually inappropriate behaviors, purposeful regurgitation/consuming vomit, anal digging/smearing or consumption of feces, and bolting. ...Needs: Needs to improve money skills. Needs to initiate own activities. Needs assistance while toileting. Needs assistance to schedule and keep appointments Needs supervision. Needs to use appropriate tone of voice when speaking. Needs to improve leisure			

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	skills. Needs to improve cooking skills. Needs to learn responsibility. Needs to improve kitchen safety skills. Needs to learn shopping skills. Needs to improve communication skills. Needs to improve socialization skills Needs to learn responsibility. Needs to improve social skills. Needs to learn to use postal services. Needs to learn about welfare facilities. Needs to learn to use banking facilities. Needs to learn to budget money. Needs to improve social interaction. Needs to learn appropriate interaction with women. Needs to learn to fill out main items on an application. Needs to learn to initiate tasks. Needs to learn to perform a job requiring use of tools or machinery. Needs to learn to have active interest in a hobby. Needs to learn to initiate group activities. Needs to learn multiplication and division. Needs to improve adding and subtracting skills Needs to improve how to use table ware correctly. AREA: Emotional Regulation GOAL: To increase knowledge of Emotional Regulation. OBJECTIVE: [Client #3] will participate in a motor skills activity with staff to use coping skills when anxious and/or stressed with 2 verbal prompts ... METHODOLOGY: 1. [Client #3] will choose the staff that he would like to be with, and they will go to a quiet area (a place where [client #3] is comfortable). 2. Staff will discuss appropriate ways to deal with anxiety/stress- Counting to 10 or 20, Walking, Deep Breathing, Thought Stopping, Drawing, Progressive Muscle Relaxation, Calm Zone Visualization, Listening to Calm Music, or using items that require motor skill activity. 3. Staff will praise [client #3] when he uses options available to him, other than physical			

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	aggression. 4. Staff will accentuate the positive in [client #3's] life. Always be upbeat and use praise when working with him 5. A successful trial will be recorded if [client #3] participates in the activity with 2 verbal prompts or less. 6. Verbal Praise for all efforts TRAINING SCHEDULE: At all appropriate opportunities. REINFORCEMENT SCHEDULE: Continuous. STAFF RESPONSIBLE: Direct Support Professional." LPN #4 was interviewed on 8/3/22 at 1:45 pm. LPN #4 stated "We treat him as a 1 on 1 because he could cause potential serious harm to himself. He goes into other clients rooms and puts anything into his mouth that he can get a hold of." RM #1 was interviewed on 8/3/22 at 1:45 pm. RM #1 stated client #3 "went into [client #9's] room and ate toothpaste from the tube." RM #1 stated, "He's so fast, it's hard to keep up with him." RM #1 indicated client #3 goes into other clients' rooms where harmful items are located. 3. Observations were conducted in the facility on 8/1/22 from 1:10 pm through 2:45 pm, from 4:20 pm through 6:55 pm, and on 8/2/22 from 7:15 am through 9:00 am. At 2:02 pm client #9 had drool on his chin and his shirt was wet on the chest. LPN # 2 prompted client #9 to change his shirt. At 2:17 pm, client #9 returned to the day room with a new shirt on backwards with drool on his chin and the chest of his shirt wet. Staff did not prompt client #9 to wipe his chin or change his shirt per his plan. At 6:17 pm, client #9 had drool on his chin and his shirt was wet on the neck and chest. Staff did not prompt client #9 to wipe his chin or			

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	change his shirt per his plan. Client #9's record was reviewed on 8/3/22 at 12:15 pm. The review indicated the following: An Individual Support Plan (ISP) dated 6/14/22 indicated in part, "Personal Dignity. GOAL: To increase responsibility for personal appearance and communication thus increasing social acceptance and independence. OBJECTIVE: [Client #9] will carry his handkerchief and use it to wipe his mouth as needed with 3 verbal prompt ... . METHODOLOGY: 1. Staff will prompt [Client #9] to carry his handkerchief. 2. Staff will prompt [Client #9] to use his handkerchief as needed when drooling. 3. If [Client #9] refuses, staff will encourage him to use the handkerchief, so his clothes stay clean, and he is appropriate in public spaces and being sanitary. 4. Staff will prompt [Client #9] to change shirts when necessary to maintain dignity. 5. A successful trial will be recorded when [Client #9] carries and wipes his mouth with his handkerchief with 3. 6. Verbal praise and recognition will be given for all efforts. TRAINING SCHEDULE: At all opportunities. REINFORCEMENT SCHEDULE: Continuous. STAFF RESPONSIBLE: DSP." The Director of Nursing (RN #1) was interviewed on 8/2/22 at 3:30 pm. RN #1 indicated client #9 had a plan to address to address his drooling behaviors. RN #1 indicated the facility got clothing protectors for client #9 but he still needed the human resources committee approval. RN #1 indicated client #9 should be prompted by			

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	staff to wipe his chin or change his shirt when he drools. 4. Observations were conducted in the facility on 8/1/22 from 1:10 pm through 2:45 pm, from 4:20 pm through 6:55 pm, and on 8/2/22 from 7:15 am through 9:00 am. On 8/1/22 at 1:18 pm, client #19 was in the gym and had drool on his chin and shirt. The Activities Coordinator did not prompt client #19 to wipe his chin or change his shirt. On 8/2/22 at 7:15 am, client #19 was on the front porch and had drool on his chin and his shirt. He had a bandana tied around his right wrist. DSP #15 did not prompt client #19 to wipe his chin with his bandana or change his shirt. Client #19's Individual Supp ort Plan dated 5/26/22 was reviewed on 8/3/22 at 12:45 pm. The reviewed indicated the following, "Area: Personal Dignity. GOAL: To increase responsibility for personal appearance and communication thus increasing social acceptance and independence.OBJECTIVE: [Client #19] will carry his handkerchief and use it to wipe his mouth as needed with 1 verbal prompt 75% of all opportunities for 3 consecutive months by 5/26/2023.METHODOLOGY: 1. Staff will prompt [Client #19] to carry his handkerchief2. Staff will prompt [Client #19] to use his handkerchief as needed when drooling3. If [client #19] refuses, staff will encourage him to use the handkerchief, so his clothes stay clean and he is appropriate in public spaces and being			

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	sanitary.4. A successful trial will be recorded when [client #19] wipes his mouth with his handkerchief with 1 or fewer verbal prompts.5. Verbal praise and recognition will be given for all efforts."5. Observations were conducted in the facility on 8/1/22 from 1:10 pm through 2:45 pm, from 4:20 pm through 6:55 pm, and on 8/2/22 from 7:15 am through 9:00 am. On 8/1/22 at 2:35 pm client #20's room had a large amount of undigested food and liquid with a strong sour odor, appearing to be vomit, on the arm of his recliner and on the floor. Client #20's shirt was wet on the chest and abdomen area with undigested food present. Client #20 stated, "I got sick." Client #20 went to the day room with the wet shirt on and Direct Support Professional (DSP) #9 said "Hey buddy" to client #20. DSP #9 did not ask client #20 what happened to his shirt. At 4:47 pm client #20 was still wearing the shirt with vomit on it. At 5:00 pm, Residential Manager (RM) #1 was in client #20's room, redirecting another client out of the room. Throughout this observation, staff did not prompt client #20 to bathe or brush his teeth per his plan. At 5:59 pm, client #20 was in the day room with the same shirt that he vomited on earlier in the day. DSP #7 asked client #20 if he wanted his food in his room. At 6:28 pm RM #2 was in client #20's room and prompted client #20 to the dining area			

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	to eat. Client #20 entered the dining area and was served his supper by RM #2. Client #20 stated to RM #2 "Thank you." Throughout this observation, staff did not prompt client #20 to bathe or brush his teeth per his plan. At 8:11 am, client #20 was in the day room wearing the same shirt he had on the day before with dried vomit. He was not prompted by staff to change his shirt. At 8:25 am, client #20 was in the dining area eating breakfast and staff did not prompt him to bathe or brush his teeth per his plan. Client #20's record was reviewed on 8/3/22 at 11:45 am. Client #20's Individual Support Plan (ISP) dated 1/14/22 indicated the following: "Needs: Needs to learn to initiate tasks. Priority objectives: Oral Hygiene. GOAL: To increase oral hygiene skills thus increasing independence.OBJECTIVE: [client #20] will brush his teeth in an up and down motion twice daily with 3 verbal prompts 60% of the opportunities per month across 12 consecutive months by 01/14/2023.METHODOLOGY: 1. Staff will explain to [client #20] the importance of brushing his teeth twice daily (fresh breath, clean mouth, and healthy gums). Staff will gather necessary supplies for objective.2. [Client #20] will brush in an up and down motion. Staff will give assistance when needed.3. A successful trial will be documented when [client #20] brushes his			

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	teeth in an up and down motion twice daily with 3 or less verbal prompts.4. Verbal praise and recognition will be given for all efforts.RISK OF SUPPORT: None. RISK OF NO SUPPORT: Oral care skills remain status quo. TRAINING SCHEDULE: At all opportunities. AREA: Personal Hygiene. GOAL: To improve personal hygiene skills thus increasing social acceptance and independence. OBJECTIVE: [Client #20] will bathe daily with 3 verbal prompts 75% of opportunities per month for 12 months by 01/14/2023.METHODOLOGY: 1. Staff will explain the importance of taking a shower daily.2. During shower time, [client #20] will be given his hygiene items.3. Staff will ask [client #20] to take a shower.4. If [client #20] refuses, staff will encourage to take his shower.5. A successful trial will be recorded when [client #20] takes his shower daily with 3 or less verbal prompts.6. Verbal praise and recognition will be given for all efforts.TRAINING SCHEDULE: At all opportunities. REINFORCEMENT SCHEDULE: Continuous." 6. Observations were conducted in the facility on 8/1/22 from 1:10 pm through 2:45 pm, from 4:20 pm through 6:55 pm, and on 8/2/22 from 7:15 am through 9:00 am. On 8/1/22 at 1:55 pm client #21 was in his room, in bed with the lights off, making snoring sounds and			

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	remained that way until 2:45 pm when the observation ended. Staff were not observed to prompt client #21 to participate in active treatment. At 2:42 pm client #21 was in his room in bed with the lights out, making snoring sounds. Staff did not prompt client #21 to get out of bed and participate in active treatment. At 4:47 pm client #21 was in his room in bed with the lights out, making snoring sounds. Staff did not prompt client #21 to get out of bed and participate in active treatment. At 5:31 pm, client #21 entered day room with a shirt and a brief on. Direct Support Professional (DSP) #16 prompted client #21 to his room to get dressed. DSP #16 stated, "he's been in bed since after lunch." Client #21's record was reviewed on 8/8/22 at 1:04 pm. Review of the ISP dated 8/11/21 indicated the following objectives: self medication skills, oral hygiene, domestics, personal safety, adaptive equipment, reporting abuse and neglect, social interaction and safety. The Director of Nursing (RN #1) was interviewed on 8/2/22 at 3:30 pm. RN #1 stated client #21 is "up at night a lot, he does not sleep well." RN #1 indicated client #21 had a plan for active treatment. RN #1 stated "staff should prompt him to get up and participate in active treatment." Licensed Practical Nurse (LPN) #4 was interviewed on 8/3/22 at 1:45 pm. LPN #4 stated client			

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	#21 "gets up at 2-3 in the morning." LPN #4 stated staff should prompt client #21 "for all meals and activities, he shouldn't be in bed for long periods of time."The Director of Nursing (RN #1) was interviewed on 8/2/22 at 3:30 pm. RN #1 indicated client #20 had plans to bathe and brush his teeth. RN #1 stated "Staff have to prompt him." RN #1 was informed that client #20's vomiting incident and RN #1 stated "I don't understand that at all; that makes me sad". RN #1 indicated staff should have prompted client #20 to bathe and brush his teeth per his plan. This deficiency was cited on 6/9/22. The facility failed to implement a systemic plan of correction to prevent recurrence.			
W 0268 Bldg. 00	483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation and interview for 1 of 4 sampled clients (client #3) plus 5 additional clients (#8, #9, #19, #20 and #21), the facility failed to promote clients #3, #8, #9, #19, #20, and #21's dignity in regards to their appearance. Findings include: Observations were completed in the facility on 8/1/22 from 1:00 PM through 1:55 PM, from 2:15 PM through 4:40 PM, from 5:00 PM through 7:20 PM, on 8/2/22 from 8:00 am through 9:00 am, 12:00 PM through 1:15 PM and on 8/3/22 from 9:00 am through 9:45 am.	W 0268	**W 268** **CORRECTION:** *These policies and procedures must promote the growth, development and independence of the client.* Specifically, facility failed to promote dignity in regard to Clients #3, #8, #9, #19, #20 and #21 appearance. Facility supervisors and staff will be retrained regarding shoes on correct feet, clothing being worn	08/29/2022

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	On 8/1/22 at 1:05 PM, client #3 wore his shirt on backwards and his sweat pants were on backwards as well. Client #8 was walking around the dining room listening to music on his tablet, his shirt was on backwards as well. Client #20 came out of his bedroom with his lunch plate, his pants were on backwards and wrong side out and the front of his shirt was wet. RM (Resident Manager) #1 stated, "[Client #20], I laid fresh clean clothes on the bed for you and you need to swallow your food." At 1:51 PM client #3 was prompted to change his clothes by RM #1. At 2:17 PM client #9 came out of his bedroom with his shoes on the wrong feet and his shirt on backwards. He was not prompted to change his shoes or shirt. At 5:04 PM, client #3's pants were falling down. He was not prompted to change into clothing that fit appropriately. At 5:30 PM client #21 came out of his bedroom in a stained t-shirt and an adult brief. Client #21 was prompted to put on pants; when he returned to the day room area he pulled his pants up and down several times. Client #21's pants were not tied at the waist and the pockets were hanging out.Observations were conducted in the facility on 8/1/22 from 1:10 PM through 2:45 PM, from 4:20 PM through 6:55 PM, and on 8/2/22 from 7:15 am through 9:00 am. On 8/1/22 at 2:09 PM client #3 had a hole in his shirt on the left shoulder as well as several tiny holes on the neckline. At 5:08 PM, client #3's pants fell below his natural waistline, exposing his brief. On 8/2/22 at 8:33 am client #3 was in the day room and his pants fell, exposing his brief and his buttocks. On 8/1/22 at 2:02 PM client #9 had drool on his chin and his shirt was wet on the chest. LPN #2 prompted client #9 to change his shirt. At 2:17		appropriately and not inside out or backwards, not wearing stained shirts, clothing being disheveled, damaged clothing, clothing not well fitting, drooling, food particles or vomit on clothing and pants falling off. **PREVENTION:** For the next 30 days, members of the Operations Team will conduct daily administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including weekend observations. After 30 days, administrative monitoring will occur no less than three times 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 ongoingsupport needed at the facility. Current Operations Team members received training from the Operations Support Specialist to assure a clear understanding of administrative monitoring as defined below. · 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.	

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	PM, client #9 returned to the day room with a new shirt on backwards with drool on his chin and the chest of his shirt wet. Staff did not prompt client #9 to wipe his chin or change his shirt. At 6:17 PM, client #9 had drool on his chin and his shirt was wet on the neck and chest. Staff did not prompt client #9 to wipe his chin or change his shirt. On 8/1/22 at 1:18 PM, client #19 had drool on his chin and shirt and staff did not redirect him to wipe his chin or change his shirt. On 8/2/22 at 7:15 am, client #19 had drool on his chin and his shirt and staff did not redirect him to wipe his chin or change his shirt. On 8/1/22 at 2:35 PM client #20's room had a large amount of undigested food and liquid with a strong sour odor, appearing to be vomit, on the arm of his recliner and on the floor. Client #20's shirt was wet on the chest and abdomen area with undigested food present. When client #20 was interviewed, client #20 stated "I got sick." Client #20 went to the day room with the wet shirt on and Direct Support Professional (DSP) #9 said "Hey buddy" to client #20. DSP #9 did not ask client #20 what happened to his shirt and DSP #9 did not prompt client #20 to change his shirt. At 4:47 PM client #20 was still wearing the shirt with vomit on it. At 5:00 PM, Residential Manager (RM) #1 was in client #20's room, redirecting another client out of the room. RM #1 did not address the vomit on client #20's shirt. At 5:59 PM, client #20 was in the day room with the same shirt that he vomited on earlier in the day. DSP #7 asked client #20 if he wanted his food in his room. DSP #7 did not address the vomit on client #20's shirt. At 6:28 PM RM #2 was in client #20's room and prompted client #20 to the dining area to eat. RM		· 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 **RESPONSIBLE PARTIES**: QIDP, Residential Manager, Direct Support Staff, Operations Team, Regional Director, Operations Support Specialist **CORRECTIONS COMPLETED BY:** 08/29/22	

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	15G811	A. BUILDING 00 B. WING	08/09/2022

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	#2 did not address the vomit on client #20's shirt. Client #20 entered the dining area and was served his supper by RM #2. Client #20 stated to RM #2 "Thank you." RM #2 did not address the vomit on client #20's shirt. At 8:11 am, client #20 was in the day room wearing the same shirt he had on the day before with dried vomit. He was not prompted by staff to change his shirt. At 8:25 am, client #20 was in the dining area eating breakfast and staff did not prompt him to change his shirt. At 5:31 PM client #21 came to the day room with a shirt and a brief on. Staff prompted him to his room to change. Client #21 entered the day room with blue pants on with the pockets pulled out. Staff did not prompt client #21 to put his pockets inside his pants. At 5:38 client #21 constantly pulled his pants and brief up and down, exposing his buttocks. DSP #7 prompted client #21 to pull his pants up on time. At 5:40 PM, client #21 continued to pull his pants and brief up and down for several minutes, exposing his buttocks. At 6:05 PM, client #21 was in the day room repeatedly pulling his pants and brief up and down exposing his buttocks. Staff did not prompt client #21 to keep his pants pulled up. At 6:14 PM, client #21 was in the day room repeatedly pulling his pants and brief up and down exposing his buttocks. Staff did not prompt client #21 to keep his pants pulled up or change his pants to ones that would stay up. The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 8/3/22 at 12:15 PM. The QIDP indicated clients' clothing should be well fitting and be in good repair. The QIDP stated "We'll have to get some new pants" for client #3. The QIDP indicated clients should be prompted to			

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	change clothing when it is soiled. The QIDP stated "Clients should not remain in soiled clothing; staff should prompt them to change." The QIDP indicated this was a dignity issue for clients. Licensed Practical Nurse (LPN) #4 was interviewed on 8/3/22 at 1:45 PM. LPN #4 stated staff should prompt clients to change soiled clothing "immediately." LPN #4 indicated this was a dignity issue for clients. This deficiency was cited on 6/9/22. The facility failed to implement a systemic plan of correction to prevent recurrence.			
W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview for 2 of 4 sample clients (#1 and #2), plus 1 additional client (#11), the facility's nursing services failed to ensure clients #1 and #2 had High Risk Plans to address their choking history and to ensure client #11's High Risk Plan for falls was updated to include a half bed rail as prescribed by a doctor and physical therapy home exercises. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed on 8/2/22 at 4:00 pm. 1. A BDDS report on 7/10/22 at 6:12 pm indicated the following: "On 7/10/2022 at approximately 6:12 pm [client #1] was taken to [Hospital] Emergency Department	W 0331	**W 331** **CORRECTION:** *The facility must provide clients with nursing services in accordance with their needs.* Specifically: the facility nurse will modify client #1 and #2 high risk plans to address history of choking and modify client #11 high risk plan for falls to include half bedrail and PT home exercises as prescribed by doctor. ·Clients #1, #2 High Risk plan have been updated to address choking with all staff trained ·Client #11 High Risk plan has been updated to include half bed rail and home exercise. The half	08/29/2022

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	where he was treated and released. [Client #1] was eating dinner, and he began coughing. He then stopped coughing and began holding his chest and throat. Nursing staff initiated abdominal thrusts which were effective at stopping choking. [Client #1] was then transported to the emergency department. Doctor assessed and [client #1] was discharged with advisement for staff to observe and return to the ED (emergency department) if he develops a fever, cough, or shortness of breath. Guardian notified. Plan to Resolve: Staff will continue to follow dietary plan. They will encourage [client #1] to take small bites, chew his food, and take drinks frequently." Client #1's record was reviewed on 8/2/22 at 10:00 am. A Nurses Note by LPN (Licensed Practical Nurse) #4 on 7/10/22 at 6:20 pm indicated nursing staff performed the Heimlich Maneuver on client #1 and sent him to the emergency room. A Nurses Note by LPN #4 on 7/12/22 indicated client #1's doctor "Ok'd" an order for a swallow evaluation. A Nurses Note by LPN #4 on 7/18/22 indicated client #1 was scheduled for a swallow evaluation on 7/27/22 at 9:30 am. A Nurses Note by LPN #4 on 8/1/22 at 9:40 am indicated client #1's swallow evaluation was re-scheduled for 8/8/22 at 9:30 am. A review of client #1's records indicated he did not have a High Risk Health Plan in place for choking. An interview was conducted with the Director of Nursing (DON) on 8/2/22 at 3:30 pm. DON indicated client #1 was on a regular diet. DON indicated client #1 did not have increased supervision ordered since the choking incident.		bed rail is present on Client #11's bed appropriately. ·All staff have been trained on observation and monitoring mealtimes to prevent Clients #3 and #4 from eating food from floor and Clients #3 and #17 from taking their peers food. **PREVENTION:** For the next 30 days, members of the Operations Team will conduct daily administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including weekend observations. After 30 days, administrative monitoring will occur no less than three times 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. Current Operations Team members received training from the Operations Support Specialist to assure a clear understanding of administrative monitoring as defined below. · 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	

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	DON indicated client #1 did not have a High Risk Health Plan for choking. DON indicated client #1 should have a plan for choking with increased supervision while eating. An interview was conducted with LPN #4 on 8/3/22 at 1:45 pm. LPN #4 stated regarding client #1's choking incidents, "He just started having them. They are always at dinner time. I did the Heimlich on him one time." LPN #4 indicated client #1 has a swallow evaluation scheduled for 8/8/22. LPN #4 stated, "I don't see any choking plans for him," after looking in client #1's chart. LPN #4 indicated client #1 should have a choking plan and stated, "Someone should always supervise him in the dining room." 2. A BDDS report dated 6/22/22 at 12:49 pm indicated the following: "On June 22, 2022, at 12:49 PM, [client #2] who is on a regular modified diet was in the dining room eating cabbage and sausage for lunch, at that time he began to gag on his food due to over stuffing his mouth. Staff approached [client #2] and assisted him with getting the food out by using a finger sweep; [Client #2] then vomited. Per ResCare procedures, staff transported [client #2] to [name] County Hospital Emergency room to be evaluated. While in the emergency room a chest x-ray was performed and came back as left lung mild patchy airspace and was diagnosed with acute bacterial bronchitis and was prescribed Zithromax (antibiotic) 250 mg (milligrams) tablets once daily for four days. [Client #2] was discharged from [name] emergency. Plan to Resolve: Staff and nurse will follow all discharge instructions and will follow up with PCP (primary care provider) if needed. Staff will continue to monitor [client #2] for any further issues or concerns and report to his treatment		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 **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Direct Support Staff, Operations Team, Regional Director, Operations Support Specialist **CORRECTIONS COMPLETED BY:** 08/29/22	

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	team." Observations were conducted in the facility on 8/1/22 from 1:10 pm through 2:45 pm, from 4:20 pm through 6:55 pm, and on 8/2/22 from 7:15 am through 9:00 am. On 8/2/22 at 7:25 am client #2 was sitting in the dining room eating a breakfast burrito unsupervised by staff. Client #2 continued to take bites of his burrito without swallowing. At 7:45 am, Residential Manager (RM) #6 noticed that client #2's mouth was full and both of his cheeks were bulging out. RM #6 prompted client #2 to spit the entire contents of his mouth out onto his plate. RM #6 stated to other staff "His mouth was stuffed full. We're going to have to watch him closer." Client #2's record was reviewed on 8/2/22 at 12:30 pm. A Nurses Note by LPN #4 dated 6/22/22 indicated, "Client stuffed mouth at lunch et (and) staff had to finger sweep mouth...Client going to [hospital] ER for eval (evaluation) et (and) tx (treatment)." A Nurses Note by LPN #4 dated 7/5/22 indicated, "Client cheeking food. Needing vp's (verbal prompts) from staff to swallow. [Doctor] notified. Awaiting response." A Nurses Note by LPN #4 dated 7/6/22 at 5:05 pm indicated, " [Doctor] with n.o.'s (new orders) for ST (speech therapy) to eval (evaluate) et (and) tx (treat) and 1/2 inch chopped food. Called ST (speech therapy) at [hospital] et (and) left message. A Speech Therapy Note dated 7/20/22 indicated, "ST (speech therapy) consult - Results/findings of examination: Have someone remind him to slow down, smaller bites, drink often between bites. Did well today with those strategies." A Nurses Note by LPN #4 on 7/20/22 at 8:45 am indicated, "Client to ST this am. Results find client			

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	eating too fast needs someone to prompt him to slow down/take smaller bites et drink often between bites." A Nurses Note by LPN #4 on 7/20/22 at 9 am indicated, " Nurse manager made aware of results." Client #2's dining plan dated 4/7/22 indicated, "Food texture: whole as prepared. Eating: [Client #2] eats independently." The dining plan did not indicate client #2 needed supervision by staff while eating to monitor for choking. The review indicated client #2 had a high risk health plan for high blood sugar dated 3/1/22, for constipation dated 3/1/22 and for hypertension (high blood pressure) dated 3/17/22. The review did not indicate client #2 had a high risk health plan for choking. An interview was conducted with LPN #4 on 8/3/22 at 1:45 pm. LPN #4 indicated client #2 has had a choking incident. LPN #4 stated, "I noticed he was stuffing his mouth and [doctor] okay'd ½ inch chopped diet and a swallow evaluation. He went to the swallow evaluation, and they said he needed to be monitored and be prompted to take smaller bites with drinks in between." LPN #4 stated client #2 should be closely monitored and stated, "Someone should be at table." LPN #4 indicated client #2 did not have a risk plan for choking. LPN #4 stated, "He should have a plan for choking." DON was interviewed on 8/2/22 at 3:30 pm. DON indicated client #2 was a choking risk. DON indicated client #2 had a speech evaluation. DON stated, "He did have a speech eval and the outcome was to slow down and drink in between bites." DON indicated this would require close			

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	supervision of client #2 while eating. DON stated, "We need to increase his supervision." DON indicated client #2 did not have a high risk health plan for choking. DON stated, "He should have a plan for choking to ensure his safety." 3. Client #11's record was reviewed on 8/3/22 at 1:00 pm. A Physician's Order dated 4/13/22 indicated the following: "Pt (physical therapy) eval (evaluate) and tx (treat) d/t (due to) multiple recent falls." A Physician's Order dated 6/7/22 indicated "1/2 bed rail to prevent falls." Observations were conducted in the facility on 8/1/22 from 1:10 pm through 2:45 pm, from 4:20 pm through 6:55 pm, and on 8/2/22 from 7:15 am through 9:00 am. On 8/2/22 at 9:00 am client #11 did not have a 1/2 rail on his bed. DON was interviewed on 8/2/22 at 3:30 pm. RN #1 indicated client #11 has had an increase in falls. DON indicated client #11 is going to physical therapy to strengthen his legs and prevent falls. DON stated "Physical Therapy feels like the exercises will help prevent the falls." DON stated "He throws his pillow, sheet and blanket on the floor and gets caught up in it when he gets up and falls." DON indicated the 1/2 rail on client #11's bed could help prevent his falls. DON indicated client #11 has a high risk plan for falls. DON indicated client #11's high risk plan for falls was not updated to include the physical therapy home exercises and the 1/2 bed rail. DON indicated client #11's high risk plan for falls should have been updated to include the physical therapy exercises and the 1/2 bed rail for client #11's safety. 5-4			

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W 0454 Bldg. 00	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), plus 16 additional clients (#6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, and #21), the facility failed to prevent clients #3 and #4 from eating food from the floor, to prevent clients #3 and #17 from taking food from their peers, to promote hand hygiene for client #3, and to ensure dining surfaces were sanitized for clients #1, #2, #3, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, and #21's evening meals. Findings include: 1. Observations were conducted in the facility on 8/1/22 from 4:45 pm to 7:20 pm. At 4:50 pm, client #4 was in the day room, sitting on the couch, and yelling loudly. Client #4 jumped up, moved the couch away from the wall, bent over, picked something up off of the floor, and it. Staff did not redirect client #4. At 6:00 pm, client #3 was was eating his dinner in the life skills building. As he was eating his cornbread, he was holding it tightly, causing it to crumble onto the floor. When client #3 finished the cornbread in his hand, he then reached down to eat cornbread off of the floor. Client #3 was not redirected by staff. At 6:15 pm, client #17 was asked if he wanted a piece of cornbread, but he did not take one. At 6:25 pm, client #17 took a piece of cornbread from his peer's plate and ate it. Client #17 was not redirected by staff. Direct Support Professional (DSP) #16 was	W 0454	**W 454** **CORRECTION:** *The facility must provide a sanitary environment to avoid sources and transmission of infections.* Specifically, all facility staff and supervisors will be retrained on mealtime infection control protocols including: · The need to clean and disinfect the dining table before and after being used for eating. · The need to prevent clients from taking food from each other. · The need to prevent clients from eating food off of the floor. · The need for handwashing prior to eating and when hands become contaminated i.e. after sneezing or coughing into them. **PREVENTION:** For the next 30 days, members of the Operations Team will conduct daily administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including weekend observations. After 30 days, administrative monitoring will occur no less than three times weekly until all staff demonstrate competence. After	08/29/2022

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	interviewed on 8/1/22 at 5:00 pm and stated, "[Client #4] moved the couch and ate a cornflake from the floor. He should have been redirected." DSP #7 was interviewed on 8/1/22 at 6:30 pm and stated, "Clients should not eat from the floor. We are short staffed. We have been for about a month. We are 2 short tonight on the evening shift." 2. Observations were conducted in the facility on 8/1/22 from 1:10 pm through 2:45 pm, from 4:20 pm through 6:55 pm, and on 8/2/22 from 7:15 am through 9:00 am. At 2:09 pm, client #3 was sitting on the couch in the day room and put his finger in his nose. Direct Support Professional (DSP) #16 was sitting one on one with client #3 and did not prompt client #3 to sanitize his hands. At 2:18 pm, client #3 drank a cup of juice that was on the table. Client #9 said loudly, "Hey, that's my juice." The Qualified Intellectual Disabilities Professional (QIDP) did not take the cup away from client #3 and allowed him to finish drinking from client #9's cup. At 4:57 pm, client #4 was in the day room and moved the couch away from the wall, picked up an item from the floor. Client #4 put the item in his mouth, chewed it and swallowed. DSP #16 stated, "Was that good?" to client #4. Residential Manager (RM) #1 stated, "What was it?" DSP #16 replied, "I think it was a frosted flake. I don't know." At 5:08 pm client #8 was prompted by DSP #9 to set the table for dinner. Client #8 set the table without cleaning the tables first. Staff did not prompt client #8 to clean the tables before setting them for clients #1, #2, #3, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, and #21's evening meal. 3. Observations were conducted in the facility on 8/1/22 from 1:10 pm through 2:45 pm, from 4:20 pm through 6:55 pm, and on 8/2/22 from 7:15 am through 9:00 am.		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. Current Operations Team members received training from the Operations Support Specialist to assure a clear understanding of administrative monitoring as defined below. · 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 **RESPONSIBLE PARTIES**: QIDP, Residential Manager, Direct Support Staff, Operations Team, Regional Director, Operations Support Specialist **CORRECTIONS COMPLETED BY:** 08/29/22	

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	On 8/1/22 at 2:35 pm client #20's room had a large amount of undigested food and liquid with a strong sour odor, appearing to be vomit, on the arm of his recliner and on the floor. Client #20's shirt was wet on the chest and abdomen area with undigested food present. When client #20 was interviewed as to what happened, client #20 stated "I got sick." Client #20 went to the day room with the wet shirt on and Direct Support Professional (DSP) #9 said "Hey buddy" to client #20. DSP #9 did not ask client #20 what happened to his shirt and DSP #9 did not prompt client #20 to change his shirt. At 2:42 pm client #20 returned to his room where the vomit remained on the chair, on the floor and on his shirt. At 4:47 pm, the vomit remained on client #20's recliner, floor and shirt. At 5:00 pm, Residential Manager (RM) #1 was in client #20's room, redirecting another client out of the room. RM #1 stated "...that did not make him happy." RM #1 did not address the vomit on client #20's recliner, floor and shirt. At 5:59 pm, client #20 was in the day room with the same shirt that he vomited on earlier in the day. DSP #7 asked client #20 if he wanted his food in his room. DSP #7 did not address the vomit on client #20's recliner, floor and shirt. At 6:28 pm RM #2 was in client #20's room and prompted client #20 to the dining area to eat. RM #2 did not address the vomit on client #20's recliner, floor and shirt. Client #20 entered the dining area and was served his supper by RM #2. Client #20 stated to RM #2 "Thank you." Client #20 was wearing the same shirt he vomited in earlier in the day. RM #2 did not address the vomit on client #20's recliner, floor and shirt. At 6:35 pm, client #3 entered client #20's room. RM #1 and RM #2 followed client #3 into client #20's room. RM #1 or RM #2 did not address the vomit that was on			

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	15G811	A. BUILDING 00 B. WING	08/09/2022

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	client #20's chair or floor. At the end of this observation, at 6:41 pm, the vomit had remained on client #20's recliner and floor. On 8/2/22 at 7:40 am, the dried vomit remained on client #20's recliner and floor. At 8:11 am, client #20 came to the day room, looked around and went back to his room. He was wearing the same shirt with dried vomit. He was not prompted to change his shirt. At 8:25 am, client #20 was in the dining area eating breakfast wearing the same shirt with dried vomit on it. The dried vomit remained on his recliner and floor. 4. Observations were conducted in the facility on 8/1/22 from 1:10 pm through 2:45 pm, from 4:20 pm through 6:55 pm, and on 8/2/22 from 7:15 am through 9:00 am. On 8/1/22 at 2:09 pm, client #3 was sitting on the couch in the day room and put his finger in his nose. Direct Support Professional (DSP) #16 was sitting one on one with client #3 and did not prompt client #3 to sanitize his hands. At 2:18 pm, client #3 drank a cup of juice that was on the table. Client #9 said loudly "Hey, that's my juice." The Qualified Intellectual Disabilities Professional (QIDP) did not take the cup away from client #3 and allowed him to finish drinking from client #9's cup. At 4:57 pm, client #4 was in the day room and moved the couch away from the wall, picked up an item from the floor. Client #4 put the item in his mouth, chewed it and swallowed. DSP #16 stated "Was that good?" to client #4. Residential Manager (RM) #1 stated "What was it?" to which DSP #16 replied "I think it was a frosted flake, I don't know."			

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	At 5:08 pm client #8 was prompted by DSP #9 to set the table for dinner. Client #8 set the table without cleaning the tables first. Staff did not prompt client #8 to clean the tables before setting them. At 6:09 pm, client #3 went into client #2's room. When client #3 came out of client #3's room, he had something in his mouth and was chewing it and had some food items in his hand. Client #3 returned to the day room and DSP #7 took the food items out of client #3's hand and crumbs landed on the floor. Client #3 then bent over and grabbed the crumbs off the floor, put them in his mouth and ate them. DSP #7 did not prompt client #3 away from the area or clean the crumbs up off the floor. On 8/2/22 at 8:23 am, client #3 left the dining table after eating breakfast. Client #13 was prompted to sit at the dining table where client #3 was previously sitting by DSP #12. The table was not cleaned after client #3 was finished eating. 5. Observations were conducted in the facility on 8/1/22 from 1:10 pm through 2:45 pm, from 4:20 pm through 6:55 pm, and on 8/2/22 from 7:15 am through 9:00 am. On 8/1/22 at 1:36 pm, the movie room had 5 large discolored areas on the carpet. The couch had a 5 inch tear on the cushion. Both arms on the couch had tears on them. At 1:55 pm the unit had a strong urine odor. There was a bucket of dirty mop water outside the day room that remained there until the observation ended. Shower room #1 had grout that was separated from the edges and had debris present. The vents in the ceiling had thick dusty debris. Shower room #2 had grout that was separated from the edges and had debris present. The vents in the ceiling			

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	had thick dusty debris. This affected clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18 #19, and #20. The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 8/3/22 at 12:15 pm. The QIDP indicated clients should be prompted to wash their hands before and after meals, before and after performing hygiene and before taking medications. The QIDP stated staff should prompt clients to perform hand hygiene "to prevent the spread of germs." The QIDP indicated dining tables should be cleaned before setting the table and clients should not be allowed to eat off the floor or drink after other clients. The QIDP stated "that could cause cross contamination of germs." The QIDP stated "The home should be clean and in good repair at all times." LPN #4 was interviewed on 8/3/22 at 1:45 pm. LPN #4 indicated staff should have cleaned client #20's vomit up immediately and sanitized the area. LPN #4 indicated the facility had a strong urine odor. LPN #4 stated, "I will come in the morning and see dirty briefs left on the floor from night shift, there are a lot of accidents during the day, it is hard for staff to keep up." LPN #4 stated "We used to have a housekeeper every day, now it's just a couple days a week; they need a housekeeper 5 days a week." LPN #4 indicated the clients should be clean and free from odor. LPN #4 indicated these were infection control issues. A review of the Center for Disease Controls Guidelines for Environmental Infection Control in Health-Care Facilities revised July 2019 was conducted on 8/3/22 at 12:00 pm. The document indicated in part, " ...cleaning and disinfecting environmental surfaces as appropriate is fundamental in reducing their potential			

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	contribution to the incidence of healthcare-associated infections ...prompt removal and surface disinfection of an area contaminated by either blood or body substances are sound infection-control practices ... Promptly clean and decontaminate spills of blood or other potentially infectious materials ...Carpet cleaning should be performed on a regular basis ... Employers are expected to make reasonable efforts to clean and sanitize carpeting using carpet detergent/cleaner products." This deficiency was cited on 6/9/22. The facility failed to implement a systemic plan of correction to prevent recurrence.			