STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G194	A. BUILDING 00 B. WING	12/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	115 STONEGATE BEDFORD, IN 47421

(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 the investigation of complaints #IN00401197 and #IN00421880. Complaint #IN00401197: No deficiencies related to the allegation(s) are cited. Complaint #IN00421880: Federal/state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W154, W157, and W227. Unrelated deficiencies cited. Survey Dates: November 30, December 1, 4 and 5, 2023 Facility Number: 000724 Provider Number: 15G194 AIM Number: 100243320 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/11/23.	W 0000		
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on record review and interview for 8 of 8 clients living in the group home (A, B, C, D, E, F, G and H), the facility failed to meet the Condition of Participation: Governing Body. The facility's governing body neglected to implement its policies and procedures to identify three clients (C, G and H) were scared of client A, prevent staff to client abuse, neglect and mistreatment, prevent	W 0102	To correct the deficient practice, Client A will not be returning to group home upon discharge from the hospital admissions. All staff have been trained regarding ResCare ANEM policy, ANEM reporting, and ensuring clients feel safe in their home. Supervisory	01/05/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patrick O'Heran	QAM	12/20/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	to client to client abuse, ensure staff immediately reported allegations of client to client abuse to the administrator, ensure thorough investigations were conducted, ensure the results of investigations were reported to the administrator within 5 working days and ensure client A had a plan to prevent him from picking at wounds on his head resulting in trips to the emergency room. Findings include: 1) Please refer to W104. For 8 of 8 clients living in the group home (A, B, C, D, E, F, G and H), the facility's governing body neglected to implement its policies and procedures to identify three clients (C, G and H) were scared of client A, prevent staff to client abuse, neglect and mistreatment, prevent to client to client abuse, ensure staff immediately reported allegations of client to client abuse to the administrator, ensure thorough investigations were conducted, ensure the results of investigations were reported to the administrator within 5 working days and ensure client A had a plan to prevent him from picking at wounds on his head resulting in trips to the emergency room. 2) Please refer to W122. For 8 of 8 clients living in the group home (A, B, C, D, E, F, G and H), the facility's governing body failed to meet the Condition of Participation: Client Protections. The facility's governing body neglected to implement its policies and procedures to identify three clients (C, G and H) were scared of client A, prevent staff to client abuse, neglect and mistreatment, prevent to client to client abuse, ensure staff immediately reported allegations of client to client abuse to the administrator, ensure thorough investigations were conducted, ensure the results of investigations were reported to the		staff have been trained regarding thorough investigations, reporting the results of an investigation the administrator within 5 working days, ensuring appropriate plans are in place and all recommendations for medical appointments implemented as written, addressing concerns reported from guardians, and assessing clients feeling safe in their home. Additional monitoring will be achieved by the Administrators completing daily observations as well as daily administrative meetings to discuss any needs of the home. The administrative team will review the observation schedule monthly for effectiveness and determine the frequency at that time. The QAM will hold weekly QA meetings with individuals responsible for investigations to: assign investigations, ensure investigations are turned in to the administrator within 5 working days, ensure investigations are thorough, and to ensure appropriate corrective actions are in place. The QIDP/AS will complete weekly assessments with clients and staff regarding the safety of the home and how the clients feel about their current living situation. Ongoing monitoring will be completed by the RM/AS/QIDP/LPN being in the home at least weekly observing, coaching, and training staff. The	

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	administrator within 5 working days and ensure client A had a plan to prevent him from picking at wounds on his head resulting in trips to the emergency room. This federal tag relates to complaint #IN00421880. 9-3-1(a)		peer review will meet to review all investigations for thoroughness, timely completion, and appropriate recommendations. Administrative staff will complete weekly site review of the home to ensure staff are trained and have the appropriate tools to complete their job thoroughly.	
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 8 of 8 clients living in the group home (A, B, C, D, E, F, G and H), the facility's governing body neglected to implement its policies and procedures to identify three clients (C, G and H) were scared of client A, prevent staff to client abuse, neglect and mistreatment, prevent to client to client abuse, ensure staff immediately reported allegations of client to client abuse to the administrator, ensure thorough investigations were conducted, ensure the results of investigations were reported to the administrator within 5 working days and ensure client A had a plan to prevent him from picking at wounds on his head resulting in trips to the emergency room. Findings include: 1) Please refer to W149. For 9 of 20 incident/investigative reports reviewed affecting clients A, B, C, D, E, F, G and H, the facility's governing body neglected to implement its policies and procedures to identify three clients were scared of client A, prevent staff to client abuse, neglect and mistreatment, prevent to client	W 0104	To correct the deficient practice, Client A will not be returning to group home upon discharge from the hospital admissions. All staff have been trained regarding ResCare ANEM policy, ANEM reporting, and ensuring clients feel safe in their home. Supervisory staff have been trained regarding thorough investigations, reporting the results of an investigation to the administrator within 5 working days, ensuring appropriate plans are in place and all recommendations for medical appointments are implemented as written, addressing concerns reported from guardians, and assessing clients feeling safe in their home. Additional monitoring will be achieved by the Administrators completing daily observations as well as daily administrative meetings to discuss any needs of the home. The	01/05/2024

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	to client abuse, ensure staff immediately reported allegations of client to client abuse to the administrator, ensure thorough investigations were conducted, ensure the results of investigations were reported to the administrator within 5 working days and ensure client A had a plan to prevent him from picking at wounds on his head resulting in trips to the emergency room. 2) Please refer to W153. For 2 of 20 incident/investigative reports reviewed affecting clients A, D, G and H, the facility's governing body failed to ensure staff immediately reported allegations of client to client abuse to the administrator. 3) Please refer to W154. For 6 of 20 incident/investigative reports reviewed affecting clients A, B, C, D, E, F, G and H, the facility's governing body failed to conduct thorough investigations. 4) Please refer to W156. For 4 of 20 incident/investigative reports reviewed affecting clients A, B, C, D, E, F, G and H, the facility's governing body failed to ensure the results of investigations were reported to the administrator within 5 working days. 5) Please refer to W157. For 7 of 20 incident/investigative reports reviewed affecting clients A, D, G and H, the facility's governing body failed to ensure appropriate corrective actions were implemented to address client A's aggression toward his peers, clients C, G and H's fear of client A and client A's skin picking after falls requiring trips to the emergency room to close the wounds he reopened. 6) Please refer to W227. For 1 of 3 clients in the		administrative team will review the observation schedule monthly for effectiveness and determine the frequency at that time. The QAM will hold weekly QA meetings with individuals responsible for investigations to: assign investigations, ensure investigations are turned into the administrator within 5 working days, ensure investigations are thorough, and to ensure appropriate corrective actions are in place. The QIDP/AS will complete weekly assessments with clients and staff regarding the safety of the home and how the clients feel about their current living situation. Ongoing monitoring will be completed by the RM/AS/QIDP/LPN being in the home at least weekly observing, coaching, and training staff. The peer review will meet to review all investigations for thoroughness, timely completion, and appropriate recommendations. Administrative staff will complete weekly site review of the home to ensure staff are trained and have the appropriate tools to complete their job thoroughly.	

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	sample (A), the facility's governing body failed to ensure client A had a plan addressing picking at his head wounds after falls with injury. This federal tag relates to complaint #IN00421880. 9-3-1(a)			
W 0122 Bldg. 00	483.420(a) CLIENT PROTECTIONS The facility must ensure the rights of all clients. Therefore the facility must Based on record review and interview for 8 of 8 clients living in the group home (A, B, C, D, E, F, G and H), the facility failed to meet the Condition of Participation: Client Protections. The facility neglected to implement its policies and procedures to identify three clients (C, G and H) were scared of client A, prevent staff to client abuse, neglect and mistreatment, prevent to client to client abuse, ensure staff immediately reported allegations of client to client abuse to the administrator, ensure thorough investigations were conducted, ensure the results of investigations were reported to the administrator within 5 working days and ensure client A had a plan to prevent him from picking at wounds on his head resulting in trips to the emergency room. Findings include: 1) Please refer to W149. For 9 of 20 incident/investigative reports reviewed affecting clients A, B, C, D, E, F, G and H, the facility neglected to implement its policies and procedures to identify three clients were scared of client A, prevent staff to client abuse, neglect and mistreatment, prevent to client to client abuse, ensure staff immediately reported allegations of client to client abuse to the administrator, ensure	W 0122	To correct the deficient practice, Client A will not be returning to group home upon discharge from the hospital admissions. All staff have been trained regarding ResCare ANEM policy, ANEM reporting, and ensuring clients feel safe in their home. Supervisory staff have been trained regarding thorough investigations, reporting the results of an investigation to the administrator within 5 working days, ensuring appropriate plans are in place and all recommendations for medical appointments are implemented as written, addressing concerns reported from guardians, and assessing clients feeling safe in their home. Additional monitoring will be achieved by the Administrators completing daily observations as well as daily administrative meetings to discuss any needs of the home. The administrative team will review the observation schedule monthly for effectiveness and determine the	01/05/2024

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	thorough investigations were conducted, ensure the results of investigations were reported to the administrator within 5 working days and ensure client A had a plan to prevent him from picking at wounds on his head resulting in trips to the emergency room. 2) Please refer to W153. For 2 of 20 incident/investigative reports reviewed affecting clients A, D, G and H, the facility failed to ensure staff immediately reported allegations of client to client abuse to the administrator. 3) Please refer to W154. For 6 of 20 incident/investigative reports reviewed affecting clients A, B, C, D, E, F, G and H, the facility failed to conduct thorough investigations. 4) Please refer to W156. For 4 of 20 incident/investigative reports reviewed affecting clients A, B, C, D, E, F, G and H, the facility failed to ensure the results of investigations were reported to the administrator within 5 working days. 5) Please refer to W157. For 7 of 20 incident/investigative reports reviewed affecting clients A, D, G and H, the facility failed to ensure appropriate corrective actions were implemented to address client A's aggression toward his peers, clients C, G and H's fear of client A and client A's skin picking after falls requiring trips to the emergency room to close the wounds he reopened. 6) Please refer to W227. For 1 of 3 clients in the sample (A), the facility failed to ensure client A had a plan addressing picking at his head wounds after falls with injury.		frequency at that time. The QAM will hold weekly QA meetings with individuals responsible for investigations to: assign investigations, ensure investigations are turned into the administrator within 5 working days, ensure investigations are thorough, and to ensure appropriate corrective actions are in place. The QIDP/AS will complete weekly assessments with clients and staff regarding the safety of the home and how the clients feel about their current living situation. Ongoing monitoring will be completed by the RM/AS/QIDP/LPN being in the home at least weekly observing, coaching, and training staff. The peer review will meet to review all investigations for thoroughness, timely completion, and appropriate recommendations. Administrative staff will complete at least a weekly site review of the home to ensure staff are trained and have the appropriate tools to complete their job thoroughly.	

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	This federal tag relates to complaint #IN00421880. 9-3-2(a)			
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 9 of 20 incident/investigative reports reviewed affecting clients A, B, C, D, E, F, G and H, the facility neglected to implement its policies and procedures to identify three clients were scared of client A, prevent staff to client abuse, neglect and mistreatment, prevent to client to client abuse, ensure staff immediately reported allegations of client to client abuse to the administrator, ensure thorough investigations were conducted, ensure the results of investigations were reported to the administrator within 5 working days and ensure client A had a plan to prevent him from picking at wounds on his head resulting in trips to the emergency room. Findings include: On 12/1/23 at 9:18 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 7/1/23 at 5:00 PM, a guardian visiting the group home witnessed abuse of client B. The 7/5/23 BDS report indicated, "...[Guardian] called to report an instance of abuse of [client B]. This occurred on or about 06/30 or 07/01. While visiting the home [client B] was sitting in his room waiting for his tablet to charge. [Client B] repeatedly attempted to retrieve his tablet. [Client B] went and got it and went in to the living room	W 0149	To correct the deficient practice, all staff have been trained regarding ResCare ANEM policy, ANEM reporting, and ensuring clients feel safe in their home. Supervisory staff have been trained regarding thorough investigations, reporting the results of an investigation the administrator within 5 working days, ensuring appropriate plans are in place and all recommendations for medical appointments are implemented as written, addressing concerns reported from guardians, and assessing clients feeling safe in their home. Additional monitoring will be achieved by the Administrators completing daily observations as well as daily administrative meetings to discuss any needs of the home. The administrative team will review the observation schedule monthly for effectiveness and determine the frequency at that time. The QAM will hold weekly QA meetings with individuals responsible for investigations to: assign investigations, ensure investigations are turned in to the	01/05/2024

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	to be with others. [Staff #7] came and yanked the tablet away from him with no warning or explanation. This caused [client B] to be agitated, rocking and grunting. The staff told him that, 'he was going back into his room.' She grabbed him by the shirt and physically swung him around and then forced him into his room. [Staff #7] is described as raising her voice and telling [client B] that, 'we will not be doing this today.'" The guardian reported the allegation on 7/5/23. The 7/12/23 Investigative Summary was a draft with red and blue corrections throughout the report. The investigation indicated, "An investigation was initiated when [guardian], someone who volunteersA volunteer guardian (sic) with [name] reported to APS (Adult Protective Services) and BDDS on 7-5-23 that she witnessed what she felt was abuse by an employee of ResCare at the [name] group home.on (sic) 7-1-23 by [former staff #7]. Report included physical abuse, mental, and emotional abuse towards [client B]... It is Substantiated that [former staff #7] was physically abusive with [client B]. It is Substantiated that [former staff #7] was verbally abusive toward [client B]." Staff #7 was terminated for abuse on 7/14/23. -The investigation was a draft as evidenced by red and blue corrections throughout the report. There were strike throughs used, changes to the wording and additional information added in red and blue. -There was no documentation the results of the investigation were reported to the administrator within 5 working days. On 11/30/23 at 2:13 PM, the Quality Assurance Coordinator (QAC) indicated the allegation was substantiated and staff #7 was terminated for		administrator within 5 working days, ensure investigations are thorough, and to ensure appropriate corrective actions are in place. The QIDP/AS will complete weekly assessments with clients and staff regarding the safety of the home and how the clients feel about their current living situation. Ongoing monitoring will be completed by the RM/AS/QIDP/LPN being in the home at least weekly observing, coaching, and training staff. The peer review will meet to review all investigations for thoroughness, timely completion, and appropriate recommendations. Administrative staff will complete at least a weekly site review of the home to ensure staff are trained and have the appropriate tools to complete their job thoroughly.	

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	abuse. The QAC indicated she was unsure how to remove the strike throughs and red and blue corrections in the report. The QAC indicated the timeframe for reporting the results of investigations to the administrator was 5 working days. On 12/1/23 at 11:32 AM, the Quality Assurance Manager (QAM) indicated the timeframe for reporting the results of investigations to the administrator was 5 working days. 2) On 8/31/23 (no time indicated), staff #4 found a glass pipe and lighter on a shelf in the bathroom at the group home. The 9/8/23 investigation indicated, "...[Staff #8] came to work at 9pm on Wednesday 8/30/23. When [staff #8] left the group home on Thursday 8/31/23, he left a meth pipe and lighter in the bathroom. DSP's (sic) [staff #4, #3 and #9] saw the pipe and lighter. [Staff #8] came back to the group home, went into the bathroom, and got the pipe and lighter. [Staff #4] did take a picture of the pipe and lighter, then called [Program Manager]...." Staff #8's statement in the investigation indicated, "Stated he got to work at 9pm on 8/30/23. Stated he worked his shift and left [name of group home] around 9:20am on 8/31/23. Stated when he got home, he remembered he left the pipe and lighter in the bathroom. Stated he got back to the group home between 9:30am and 9:45am. Stated he went into the home, went to the bathroom, got the pipe and lighter, and then he left. Stated he did not mean to bring the pipe into the home. Stated he had been in a hurry when he got out of his car and accidentally picked up the pipe. Stated it fell out of his pocket in the bathroom, and he laid it on the shelf and then forgot about it. Stated he did not use any drugs while on the job. Stated the pipe was a meth pipe." The investigation indicated,			

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	"...Conclusion: It is substantiated [staff #8] left a meth pipe and lighter on the bathroom shelf at [name of group home]. Addendum 10-2-23: It is substantiated [staff #8] violated Rescare Drug and Alcohol-Free Workplace Policy." Staff #8 was terminated on 10/2/23. -There were no interviews asking if staff #8 seemed to be under the influence of drugs while at work on 8/31/23 or any other day. -There was no documentation the results of the investigation were reported to the administrator within 5 working days. On 12/1/23 at 11:32 AM, the Quality Assurance Manager (QAM) indicated no one reported concerns about former staff #8 being under the influence of drugs while working at the group home. The QAM indicated the investigation should have asked staff if they suspected staff #8 working while under the influence of drugs. The QAM indicated the investigation was not thorough. The QAM indicated the timeframe for reporting the results of investigations to the administrator was 5 working days. On 12/1/23 at 11:32 AM, the Quality Assurance Coordinator (QAC) stated, when asked if she addressed staff #8 being under the influence of drugs at the group home, "I know I did but didn't put it in the investigation." The QAC indicated the investigation was not thorough without this information. The QAC indicated the timeframe for reporting the results of investigations to the administrator was 5 working days. 3A) A 10/24/23 Investigative Summary indicated, "On 10/14/23 at 12:46pm the clients of [name of group home] were outside, [client A] was upset			

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	because he forgot his book, staff asked him to wait a minute and they would go and get it. [Client A] then went over to [client G] and twisted his ear, he then reached over to [client D] and bent to fingers backward. Staff intervened and redirected [client A] back into the house and counseled him on not hurting his peers and using his coping skills when he becomes upset. Both [clients D and G] were checked out for any injuries and none were found." -The 10/23/23 BDS report indicated staff reported the incident to the administrator on 10/23/23. Staff failed to immediately report allegations of abuse to the administrator. -There were no interviews with clients D and G. The investigation was not thorough. -The investigation included one staff interview. The investigation did not include which staff was working at the time of the incident. The investigation was not thorough. -The investigation indicated, "All plans, policy, and procedures were followed appropriately." The investigation failed to identify client A's Behavior Support Plan for physical aggression not being implemented to prevent it from happening. The investigation was not thorough. -The results of the investigation were not submitted to the administrator within 5 working days. On 12/1/23 at 11:32 AM, the QAM indicated staff should immediately notify the administrator of allegations of abuse. The QAM indicated the investigation was not thorough. He indicated the investigation should identify the staff present at			

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	the time of the incident and include interviews with all pertinent staff and clients. The QAM indicated the timeframe for reporting the results of investigations was 5 working days. On 12/1/23 at 11:32 AM, the QAC indicated staff should immediately notify the administrator of allegations of abuse. The QAC indicated the investigation was not thorough. She indicated the investigation should identify the staff present at the time of the incident and include interviews with all pertinent staff and clients. 3B) A 10/24/23 Investigation Summary indicated, "On 10/16/23 at 5:07pm the clients were eating dinner. [Client A] got done eating first and wanted to color using the dining room table. Staff asked him to wait until supper was over so he would have more room, since everyone else was still eating. [Client A] became upset, he reached over and pulled on [client H's] ear. Staff redirected [client A], staff counseled him on using his coping skills when he is upset. [Client H] was checked for injuries to his ears and none were found." -The staff failed to immediately report an allegation of abuse to the administrator. -The investigation did not include an interview with client H or his peers. The investigation was not thorough. -The investigation did not indicate how many staff were present at the time of the incident. There was one staff interviewed for the investigation. The investigation was not thorough. -The investigation indicated, "All plans, policy,			

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	and procedures were followed appropriately... Staff will continue to follow his HRC (Human rights committee) and guardian approved BSP (behavior support plan)." The investigation was not thorough. -The results of the investigation were not submitted to the administrator within 5 working days. On 12/1/23 at 11:32 AM, the QAM indicated staff should immediately notify the administrator of allegations of abuse. The QAM indicated the investigation was not thorough. He indicated the investigation should identify the staff present at the time of the incident and include interviews with all pertinent staff and clients. The QAM indicated the QIDP would be retrained on conducting thorough investigations. The QAM indicated the timeframe for reporting the results of investigations was 5 working days. On 12/1/23 at 11:32 AM, the QAC indicated staff should immediately notify the administrator of allegations of abuse. The QAC indicated the investigation was not thorough. She indicated the investigation should identify the staff present at the time of the incident and include interviews with all pertinent staff and clients. 3C) On 10/23/23 at 3:45 PM, the 10/24/23 BDS report indicated, "On 10/23/23 at 3:45pm [client A] came into the kitchen, he was yelling because he broke his plastic pumpkin and staff could not fix it. Staff tried to redirect him, and spend 1:1 (one on one) with him to help him calm down. [Client A] refused to be redirected, he went up to [client D] and pushed him. [Client D] was standing by a kitchen chair, staff kept him from falling completely over the chair. [Client A] realizing			

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	what he did, went straight to his room without staff directing him to, he stayed in his room until he calmed down. Staff talked to him after about being nice to his peers. [Client D] was checked for any injuries, a quarter sized bruise was found on [client D's] upper right arm where it hit the back of the chair...." -The 10/24/23 Investigation Summary contained the same information included in the 10/16/23. The investigation also included information regarding a client living in a different group home. There were no interviews with the staff and clients involved in the incident. The investigation was not thorough. On 12/1/23 at 11:32 AM, the QAM indicated the investigation was not thorough. The QAM indicated the client referenced in the investigation lived in a different group home and should not have been included in the investigation. On 12/1/23 at 11:32 AM, the QAC indicated the investigation was not thorough. On 11/30/23 at 2:13 PM, the Quality Assurance Coordinator (QAC) indicated prior to client A moving into the group home, she thought it was a good placement. The QAC indicated the group home was not used to behaviors. The QAC stated, "I think he'd be better off with higher functioning clients. The QAC indicated she was not aware of any of client A's peers being afraid of him and none of the clients act scared of him. On 11/30/23 at 2:36 PM, the Qualified Intellectual Disabilities Professional (QIDP) stated client A was admitted to a psychiatric hospital due to "things not going well." The QIDP indicated client A's behaviors were affecting the other			

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	clients: client C gets down and cries, client H biting his hand and points at client A, and client G staying close to the staff. The QIDP indicated the group home was calm before client A moved in. On 12/1/23 at 2:10 PM, the nurse stated it was "pretty calm at the home prior to when he (client A) moved in." The nurse indicated clients C and G have been affected the most by client A's presence in the home. The nurse indicated client C complained of stomach issues when client A was home with him. The nurse indicated client C was spending more time in his bedroom isolating himself from client A. The nurse indicated client G, when client A was having behaviors, would shake and cry. The nurse stated she "had to sit with him and pat him on the shoulder to comfort him." The nurse indicated while she was sitting with client G, he was pointing at client A indicating client A was bothering him. The nurse stated "Last week, [client G] was curled up in a ball upset and sad looking due to [client A]." The nurse indicated she observed client G on 11/30/23 while client A was in the psychiatric hospital and he was happy, excited, and seemed to be back to his normal self due to client A being gone. The nurse stated, "[Client A] is not appropriately placed at the group home." On 11/30/23 at 11:30 AM, staff #3 indicated she did not think client A was appropriately placed at the group home. Staff #3 stated client A was "not an appropriate fit for the home." Staff #3 stated client A "doesn't listen, yells and screams. Had the house in an uproar... [Client C] been upset, others as well. [Client A] has client to client (aggression) with [clients D, H and G]...." On 11/30/23 at 11:55 AM, the guardian for clients B, C, D and G indicated she had been concerned			

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	about the clients' safety and wellbeing since client A moved into the group home. The guardian indicated she called BDS, Program Manager and the QIDP to express her concerns but received no responses alleviating her concerns. The guardian indicated the BDS representative told her it was client A's home as well. The guardian indicated client C had been emotional since client A moved in. On 11/30/23 at 12:17 PM, staff #4 indicated client A was not appropriately placed at the group home. Staff #4 stated client A was OK for awhile but since then had "caused a lot of problems." Client H has been biting his hands. Client C has been crying and more emotional. Staff #4 stated client A moving in, "Changed the whole dynamics of the house... Ripple effect. Whole dynamics changed." On 11/30/23 at 12:33 PM, client G indicated client A bothered him. Client G, when asked if he was scared of client A, indicated yes. On 11/30/23 at 12:42 PM, client H indicated client A bothered him. Client H hit his hand when the surveyor asked him about client A. Client H touched his head and said yes when asked if he was scared of client A. On 11/30/23 at 12:46 PM, staff #3 indicated the staff working at the group home did not document client A's behaviors as they should have. Staff #3 indicated the staff was told client A had no maladaptive behaviors when he moved in. On 11/30/23 at 12:53 PM, staff #4 indicated there was one night (she did not recall the date) the overnight shift staff moved client A's roommate's bed out of their bedroom and into the kitchen due			

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	to client A's screaming and turning the lights on and off in the room. Staff #4 stated client A "turned the house upside down. Clients nervous and upset. [Client F's] rectal digging increased when [client A's] behaviors increased." Staff #4 indicated since client A was in the psychiatric hospital, client C was much calmer, client H's hand biting decreased and client F was sleeping better. Staff #4 stated the home was "much calmer with [client A] gone." On 11/30/23 at 1:30 PM, client C stated "[Client A's] behaviors scare me. He got mad, angry, he hit me. Makes me nervous." Client C stated it was "a lot better with him gone. He bothers others as well. Everybody seems afraid of him. He's up all night. He falls a lot." On 11/30/23 at 2:36 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure prohibiting abuse. On 12/1/23 at 11:32 AM, the Quality Assurance Manager (QAM) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QAM indicated the facility had a policy and procedure prohibiting abuse. He indicated the staff should immediately report abuse to the administrator. The QAM indicated the incidents were not reported to BDS within 24 hours due to the staff failing to report abuse to the administrator immediately. On 11/30/23 at 2:13 PM, the Quality Assurance Coordinator (QAC) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QAC indicated			

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	the facility had a policy and procedure prohibiting abuse. 4A) On 11/3/23 at 5:42 AM, client A fell in his bedroom. The 11/3/23 BDS report indicated, "On 11/3/23 at 5:42am third shift staff was doing room checks. The staff reported that [client A] had already been up and had opened his door to his room a couple of times. Staff was going to check on him and his roommate. When staff opened the door, [client A] went to turn around and fell. He hit his head on the floor. Staff immediately went to [client A]. They asked him if he could set (sic) up, [client A] replied yes. Staff asked him if he hurt anywhere besides his head, [client A] replied no. Staff helped him up and to the couch, staff applied pressure to his head and called 911. Staff reported that [client A] had a 2" by 1cm (centimeter) cut on the left side of his forehead and it was bleeding. EMS (Emergency Medical Services) showed up and took [client A] to the hospital. The hospital did scans and everything came back negative. [Client A] was released at 10:45am. Staff is doing head tracking on him and will continue to monitor him." 4B) On 11/10/23 at 1:58 AM, client A exited his bedroom and his head was bleeding. The 11/10/23 BDS report indicated, "On 11/10/23 at 1:58am [client A] came out of his room, staff noticed that his head was bleeding. [Client A] had ripped his stitches from his fall on 11/3/23 (IR#1520852). Staff applied pressure to his head and called for an ambulance. EMS arrived at 2:08am, they assessed [client A] and left for the ER at 2:16am. The ER stitched his head again. The stitches will dissolve on their own in 3-8 days. The ER sent him home. Staff will follow the instructions that the ER put on his discharge paper. Keeping the laceration clean and dry,			

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	covered and they may apply bacitracin (antibiotic ointment). Staff will monitor [client A] to make sure that he is redirected from rubbing the laceration." On 11/30/23 at 12:45 PM, a focused review of client A's daily charting was conducted. An 11/30/23 note on the back of client A's behavior tracking sheet indicated, "Ripped open a wound on his forehead w/ (with) his fingers. Took to ER." An 11/13/23 Incident Follow-Up Report indicated, "Did the Individual rip his stitches intentionally or was it accidental? We believe it was accidental. His stitches were fine when he went to bed. Our nurse thinks that it was probably itching from the healing and he was rubbing or scratching it in his sleep." 4C) On 11/13/23 at 5:10 PM, client A fell in the dining room. The 11/14/23 BDS report indicated, "On 11/13/23 at 5:10pm [client A] got up from the dining room table. He picked up his plate and turned to take his plate to the sink, he lost his balance and fell backwards. He hit his head on the floor. The staff went to him and helped him sit up. They asked him if he could stand and he said yes. They helped him up and onto a chair. Staff checked his head, they found a 1" (inch) wound that was bleeding. Staff called the nurse, the nurse told staff to send him to the ER. Staff called for an ambulance. The EMS arrived and took [client A] to the ER. At the ER he received two staples to close his wound. He will have the staples removed in 10 days. He will follow up with [name of doctor] in 1 to 2 weeks...." The 11/16/23 Investigative Summary indicated, "[Client A] fell on 11.13.23 when getting up from			

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	the dining room table to take his plate to the sink. [Client A] stood up from the table, he went to turn and lost his balance and fell backwards. [Client A's] walker was behind his chair and available to him. [Client A] has a 1" wound on the back of his head. [Client A] received two staples to close the wound. According to discharge papers, the wound on [client A's] forehead from a previous incident was also treated. It was found he had picked out the stitches. The wound could not be stitched again, they cleaned it, bandaged it, and then wrapped his head so he could not pick at it. The wound on his forehead is infected. [Client A] was prescribed antibiotics by the ER doctor. No one noticed that his wound was infected. [Staff #2] was the staff on duty... Conclusion: It is substantiated risk plans were followed at the time [client A] fell on 11/13/23. Fall risk plan states that he should be encouraged to use his walker and staff are to help with ambulation when needed." On 12/1/23 at 12:58 PM, a focused review of client A's medical record was conducted. Client A's 11/13/23 Discharge Instructions indicated, "...Diagnosis from today's visit: Fall. Head injury. Laceration of head. Infected wound. Compulsive skin picking... What to do next: ...Keep forehead wound covered, do not allow picking. Strong head wrap dressing, knit hat or toboggan over dressing. Discuss hand mits (sic) with patient's PCP (primary care provider) if necessary. Antibiotics as prescribed. Clindamycin 300 mg (milligrams/antibiotic) three times a day for secondary wound infection due to self picking. Follow up with [name of doctor] to discuss possible repair or further wound care. Staples to posterior head lac (laceration) must stay covered as well. Do not allow picking. Staples need removed in 10 days...."			

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	On 12/1/23 at 1:01 PM, a review of an interdisciplinary team meeting on 11/14/23 was conducted. The notes indicated, "...Staff report unsteadiness and that there were no falls prior to the new medication of Clonazepam and Ambien. The team does not believe the Ambien is a benefit. [Name of nurse] will inquire further with the doctor and advocate a D/C (discontinue) if appropriate. The team reviewed each of the falls and the factors surrounding the incidents. [Name of nurse] will continue to maintain contact with wound care. Hand mittens were proposed as a tool to help [client A's] injuries heal...." The IDT did not indicate whether or not the IDT agreed with the recommendation to use hand mitts. There was no documentation the IDT discussed a knit hat or toboggan. On 12/1/23 at 10:27 AM, a review of client A's risk plans and program plans was conducted. Client A did not have a plan for skin picking. There was no plan to keep client A's head covered. There was no plan for the use of a knit hat or toboggan. There was no plan for the use of hand mitts. On 12/1/23 at 11:32 AM, the QAM indicated staff #2 was working alone at the time of the incident. The QAM indicated one staff during waking hours was not sufficient to manage and supervise the clients according to their program plans. The QAM indicated the investigation should have the staffing level at the group home. The QAM indicated due to the investigation not addressing one staff working at the time of the incident, the investigation was not thorough. On 12/1/23 at 11:32 AM, the QAC indicated staff #2 was working alone at the time of the incident. The QAC indicated one staff during waking hours was not sufficient to manage and supervise the			

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	clients according to their program plans. The QAC indicated the investigation should have the staffing level at the group home. The QAC indicated due to the investigation not addressing one staff working at the time of the incident, the investigation was not thorough. On 12/5/23 at 9:09 AM, the nurse indicated she bought mittens and took them to the group home. The nurse indicated she did not think client A used the mittens due to his wounds being bandaged well. The nurse indicated client A wore a toboggan or a Santa Claus hat. The nurse stated "I didn't put in plan." The nurse indicated she was not aware of a plan to prevent client A from picking at his wounds. The nurse indicated there was no plan for mittens, hat and keeping his head covered to prevent him from picking. On 12/5/23 at 9:17 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated he left the IDT unclear whether or not the team agreed to the use of the mittens. The QIDP indicated he should have clarified whether or not the team agreed and documented it on the form. The QIDP indicated although interventions were put in place to prevent client A from picking at his wounds, there was no plan addressing the interventions. The QIDP indicated client A wore a hat and staff wrapped the wound better. The QIDP indicated there was no plan for skin picking, use of a hat, keeping his head covered and bandaging the wound. On 12/5/23 at 9:24 AM, the Associate Executive Director (AED) indicated there should have been a written plan developed for skin picking including keeping his head covered, wearing a hat, bandage and the use of mittens.			

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	4D) On 11/21/23 at 10:20 PM, client A fell in his bedroom. The 11/22/23 BDS report indicated, "On 11/21/23 at 10:20pm staff heard [client A's] bedroom door open and then a thud. Staff was already on their way to his room. [Client A] had fell (sic). Staff helped him up and into the living room. They checked him over and found a knot forming on the back of his head. They called for an ambulance. The EMS (Emergency Medical Services) arrived and took [client A] to the ER. They did a CT (computed tomography)scan of his head and spine. All scans came back negative. He was discharged from the ER...." -There was no documentation of an investigation. On 12/1/23 at 11:32 AM, the Quality Assurance Manager (QAM) indicated an investigation should have been conducted. On 12/4/23 at 12:47 PM, a review of the facility's 11/10/23 Reporting and Investigating Abuse, Neglect, Exploitation, Mistreatment or a Violation of Individual's Rights policy was conducted. The policy indicated, "ResCare staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of ResCare, local, state and federal guidelines... ResCare strictly prohibits abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights... Any ResCare staff person who suspects an individual is the victim of abuse, neglect, exploitation or mistreatment of an individual should immediately notify the Program Manager...."			

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	This federal tag relates to complaint #IN00421880. 9-3-2(a)			
W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 2 of 20 incident/investigative reports reviewed affecting clients A, D, G and H, the facility failed to ensure staff immediately reported allegations of client to client abuse to the administrator. Findings include: On 12/1/23 at 9:18 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) A 10/24/23 Investigative Summary indicated, "On 10/14/23 at 12:46pm the clients of [name of group home] were outside, [client A] was upset because he forgot his book, staff asked him to wait a minute and they would go and get it. [Client A] then went over to [client G] and twisted his ear, he then reached over to [client D] and bent to fingers backward. Staff intervened and redirected [client A] back into the house and counseled him on not hurting his peers and using his coping skills when he becomes upset. Both [clients D and G] were checked out for any injuries and none were found." -The 10/23/23 BDS report indicated staff reported	W 0153	To correct the deficient practice, all staff have been trained regarding ResCare ANEM policy and ANEM reporting. Additional monitoring will be achieved by the Administrators completing daily observations as well as daily administrative meetings to discuss any needs of the home. The administrative team will review the observation schedule monthly for effectiveness and determine the frequency at that time. Ongoing monitoring will be completed by the RM/AS/QIDP/LPN being in the home at least weekly observing, coaching, and training staff.	01/05/2024

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	15G194	A. BUILDING 00 B. WING	12/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	115 STONEGATE BEDFORD, IN 47421

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	the incident to the administrator on 10/23/23. Staff failed to immediately report allegations of abuse to the administrator. 2) A 10/24/23 Investigation Summary indicated, "On 10/16/23 at 5:07pm the clients were eating dinner. [Client A] got done eating first and wanted to color using the dining room table. Staff asked him to wait until supper was over so he would have more room, since everyone else was still eating. [Client A] became upset, he reached over and pulled on [client H's] ear. Staff redirected [client A], staff counseled him on using his coping skills when he is upset. [Client H] was checked for injuries to his ears and none were found." -The staff failed to immediately report an allegation of abuse to the administrator. On 12/1/23 at 11:32 AM, the Quality Assurance Manager indicated staff should immediately notify the administrator of allegations of abuse. On 12/1/23 at 11:32 AM, the Quality Assurance Coordinator indicated staff should immediately notify the administrator of allegations of abuse. 9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 6 of 20 incident/investigative reports reviewed affecting clients A, B, C, D, E, F, G and H, the facility failed to conduct thorough investigations. Findings include:	W 0154	To correct the deficient practice, all staff have been trained regarding ResCare ANEM policy and ANEM reporting. Supervisory staff have been trained on reporting the results of an	01/05/2024

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	On 12/1/23 at 9:18 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 7/1/23 at 5:00 PM, a guardian visiting the group home witnessed abuse of client B. The 7/5/23 BDS report indicated, "...[Guardian] called to report an instance of abuse of [client B]. This occurred on or about 06/30 or 07/01. While visiting the home [client B] was sitting in his room waiting for his tablet to charge. [Client B] repeatedly attempted to retrieve his tablet. [Client B] went and got it and went in to the living room to be with others. [Staff #7] came and yanked the tablet away from him with no warning or explanation. This caused [client B] to be agitated, rocking and grunting. The staff told him that, 'he was going back into his room.' She grabbed him by the shirt and physically swung him around and then forced him into his room. [Staff #7] is described as raising her voice and telling [client B] that, 'we will not be doing this today.'" The guardian reported the allegation on 7/5/23. The 7/12/23 Investigative Summary was a draft with red and blue corrections throughout the report. The investigation indicated, "An investigation was initiated when [guardian], someone who volunteersA volunteer guardian (sic) with [name] reported to APS (Adult Protective Services) and BDDS on 7-5-23 that she witnessed what she felt was abuse by an employee of ResCare at the [name] group home.on (sic) 7-1-23 by [former staff #7]. Report included physical abuse, mental, and emotional abuse towards [client B]... It is Substantiated that [former staff #7] was physically abusive with [client B]. It is Substantiated that [former staff #7] was verbally abusive toward [client B]." Staff #7 was terminated for abuse on 7/14/23.		investigation to the administrator within 5 working days. Additional monitoring will be achieved by the Administrators completing daily observations as well as daily administrative meetings to discuss any needs of the home. The administrative team will review the observation schedule monthly for effectiveness and determine the frequency at that time. The QAM will hold weekly QA meetings with individuals responsible for investigations to: assign investigations and ensure investigations are turned in to the administrator within 5 working days. Ongoing monitoring will be completed by the RM/AS/QIDP/LPN being in the home at least weekly observing, coaching, and training staff. The peer review will meet to review all investigations for thoroughness, timely completion, and appropriate recommendations.	

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	-The investigation was a draft as evidenced by red and blue corrections throughout the report. There were strike throughs used, changes to the wording and additional information added in red and blue. On 11/30/23 at 2:13 PM, the Quality Assurance Coordinator (QAC) indicated the allegation was substantiated and staff #7 was terminated for abuse. The QAC indicated she was unsure how to remove the strike throughs and red and blue corrections in the report. 2) On 8/31/23 (no time indicated), staff #4 found a glass pipe and lighter on a shelf in the bathroom at the group home. The 9/8/23 investigation indicated, "...[Staff #8] came to work at 9pm on Wednesday 8/30/23. When [staff #8] left the group home on Thursday 8/31/23, he left a meth pipe and lighter in the bathroom. DSP's (sic) [staff #4, #3 and #9] saw the pipe and lighter. [Staff #8] came back to the group home, went into the bathroom, and got the pipe and lighter. [Staff #4] did take a picture of the pipe and lighter, then called [Program Manager]...." Staff #8's statement in the investigation indicated, "Stated he got to work at 9pm on 8/30/23. Stated he worked his shift and left [name of group home] around 9:20am on 8/31/23. Stated when he got home, he remembered he left the pipe and lighter in the bathroom. Stated he got back to the group home between 9:30am and 9:45am. Stated he went into the home, went to the bathroom, got the pipe and lighter, and then he left. Stated he did not mean to bring the pipe into the home. Stated he had been in a hurry when he got out of his car and accidentally picked up the pipe. Stated it fell out of his pocket in the bathroom, and he laid it on the shelf and then forgot about it. Stated he did not			

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	use any drugs while on the job. Stated the pipe was a meth pipe." The investigation indicated, "...Conclusion: It is substantiated [staff #8] left a meth pipe and lighter on the bathroom shelf at [name of group home]. Addendum 10-2-23: It is substantiated [staff #8] violated Rescare Drug and Alcohol-Free Workplace Policy." Staff #8 was terminated on 10/2/23. -There were no interviews asking if staff #8 seemed to be under the influence of drugs while at work on 8/31/23 or any other day. On 12/1/23 at 11:32 AM, the Quality Assurance Manager (QAM) indicated no one reported concerns about former staff #8 being under the influence of drugs while working at the group home. The QAM indicated the investigation should have asked staff if they suspected staff #8 working while under the influence of drugs. The QAM indicated the investigation was not thorough. On 12/1/23 at 11:32 AM, the Quality Assurance Coordinator (QAC) stated, when asked if she addressed staff #8 being under the influence of drugs at the group home, "I know I did but didn't put it in the investigation." The QAC indicated the investigation was not thorough without this information. 3) A 10/24/23 Investigative Summary indicated, "On 10/14/23 at 12:46pm the clients of [name of group home] were outside, [client A] was upset because he forgot his book, staff asked him to wait a minute and they would go and get it. [Client A] then went over to [client G] and twisted his ear, he then reached over to [client D] and bent to fingers backward. Staff intervened and redirected [client A] back into the house and counseled him			

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	on not hurting his peers and using his coping skills when he becomes upset. Both [clients D and G] were checked out for any injuries and none were found." -There were no interviews with clients D and G. The investigation was not thorough. -The investigation included one staff interview. The investigation did not include which staff was working at the time of the incident. The investigation was not thorough. -The investigation indicated, "All plans, policy, and procedures were followed appropriately." The investigation failed to identify client A's Behavior Support Plan for physical aggression not being implemented to prevent it from happening. The investigation was not thorough. On 12/1/23 at 11:32 AM, the QAM indicated the investigation was not thorough. He indicated the investigation should identify the staff present at the time of the incident and include interviews with all pertinent staff and clients. On 12/1/23 at 11:32 AM, the QAC indicated the investigation was not thorough. She indicated the investigation should identify the staff present at the time of the incident and include interviews with all pertinent staff and clients. 4) A 10/24/23 Investigation Summary indicated, "On 10/16/23 at 5:07pm the clients were eating dinner. [Client A] got done eating first and wanted to color using the dining room table. Staff asked him to wait until supper was over so he would have more room, since everyone else was still eating. [Client A] became upset, he reached over and pulled on [client H's] ear. Staff redirected			

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	[client A], staff counseled him on using his coping skills when he is upset. [Client H] was checked for injuries to his ears and none were found." -The investigation did not include an interview with client H or his peers. The investigation was not thorough. -The investigation did not indicate how many staff were present at the time of the incident. There was one staff interviewed for the investigation. The investigation was not thorough. -The investigation indicated, "All plans, policy, and procedures were followed appropriately... Staff will continue to follow his HRC (Human rights committee) and guardian approved BSP (behavior support plan)." The investigation was not thorough. On 12/1/23 at 11:32 AM, the QAM indicated the investigation was not thorough. He indicated the investigation should identify the staff present at the time of the incident and include interviews with all pertinent staff and clients. The QAM indicated the QIDP would be retrained on conducting thorough investigations. On 12/1/23 at 11:32 AM, the QAC indicated the investigation was not thorough. She indicated the investigation should identify the staff present at the time of the incident and include interviews with all pertinent staff and clients. 5) On 10/23/23 at 3:45 PM, the 10/24/23 BDS report indicated, "On 10/23/23 at 3:45pm [client A] came into the kitchen, he was yelling because he broke his plastic pumpkin and staff could not fix it.			

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	Staff tried to redirect him, and spend 1:1 (one on one) with him to help him calm down. [Client A] refused to be redirected, he went up to [client D] and pushed him. [Client D] was standing by a kitchen chair, staff kept him from falling completely over the chair. [Client A] realizing what he did, went straight to his room without staff directing him to, he stayed in his room until he calmed down. Staff talked to him after about being nice to his peers. [Client D] was checked for any injuries, a quarter sized bruise was found on [client D's] upper right arm where it hit the back of the chair...." -The 10/24/23 Investigation Summary contained the same information included in the 10/16/23. The investigation also included information regarding a client living in a different group home. There were no interviews with the staff and clients involved in the incident. The investigation was not thorough. On 12/1/23 at 11:32 AM, the QAM indicated the investigation was not thorough. The QAM indicated the client referenced in the investigation lived in a different group home and should not have been included in the investigation. On 12/1/23 at 11:32 AM, the QAC indicated the investigation was not thorough. 6) On 11/21/23 at 10:20 PM, client A fell in his bedroom. The 11/22/23 BDS report indicated, "On 11/21/23 at 10:20pm staff heard [client A's] bedroom door open and then a thud. Staff was already on their way to his room. [Client A] had fell (sic). Staff helped him up and into the living room. They checked him over and found a knot forming on the back of his head. They called for an ambulance. The EMS (Emergency Medical			

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	Services) arrived and took [client A] to the ER. They did a CT (computed tomography)scan of his head and spine. All scans came back negative. He was discharged from the ER...." -There was no documentation of an investigation. On 12/1/23 at 11:32 AM, the Quality Assurance Manager (QAM) indicated an investigation should have been conducted. This federal tag relates to complaint #IN00421880. 9-3-2(a)			
W 0156 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 4 of 20 incident/investigative reports reviewed affecting clients A, B, C, D, E, F, G and H, the facility failed to ensure the results of investigations were reported to the administrator within 5 working days. Findings include: On 12/1/23 at 9:18 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 7/1/23 at 5:00 PM, a guardian visiting the group home witnessed abuse of client B. The 7/5/23 BDS report indicated, "...[Guardian] called to report an instance of abuse of [client B]. This occurred on or about 06/30 or 07/01. While	W 0156	To correct the deficient practice, supervisory staff have been trained in reporting the results of an investigation to the administrator within 5 working days, and ensuring appropriate corrective actions are in place. Additional monitoring will be achieved by The QAM holding weekly QA meetings with individuals responsible for investigations to: assign investigations, ensure investigations are turned into the administrator within 5 working days, ensure investigations are thorough, and to ensure appropriate corrective actions are in place. The QAM will track all	01/05/2024

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	visiting the home [client B] was sitting in his room waiting for his tablet to charge. [Client B] repeatedly attempted to retrieve his tablet. [Client B] went and got it and went in to the living room to be with others. [Staff #7] came and yanked the tablet away from him with no warning or explanation. This caused [client B] to be agitated, rocking and grunting. The staff told him that, 'he was going back into his room.' She grabbed him by the shirt and physically swung him around and then forced him into his room. [Staff #7] is described as raising her voice and telling [client B] that, 'we will not be doing this today.'" The guardian reported the allegation on 7/5/23. The 7/12/23 Investigative Summary was a draft with red and blue corrections throughout the report. The investigation indicated, "An investigation was initiated when [guardian], someone who volunteersA volunteer guardian (sic) with [name] reported to APS (Adult Protective Services) and BDDS on 7-5-23 that she witnessed what she felt was abuse by an employee of ResCare at the [name] group home.on (sic) 7-1-23 by [former staff #7]. Report included physical abuse, mental, and emotional abuse towards [client B]... It is Substantiated that [former staff #7] was physically abusive with [client B]. It is Substantiated that [former staff #7] was verbally abusive toward [client B]." Staff #7 was terminated for abuse on 7/14/23. -There was no documentation the results of the investigation were reported to the administrator within 5 working days. 2) On 8/31/23 (no time indicated), staff #4 found a glass pipe and lighter on a shelf in the bathroom at the group home. The 9/8/23 investigation indicated, "...[Staff #8] came to work at 9pm on Wednesday 8/30/23. When [staff #8] left the		investigations and report to the ED any concerns. The peer review will meet to review all investigations for thoroughness, timely completion, and appropriate recommendations. Ongoing monitoring will be achieved by the quality and safety committee meeting to discuss previous investigations and recommendations for effectiveness, and patterns.	

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	group home on Thursday 8/31/23, he left a meth pipe and lighter in the bathroom. DSP's (sic) [staff #4, #3 and #9] saw the pipe and lighter. [Staff #8] came back to the group home, went into the bathroom, and got the pipe and lighter. [Staff #4] did take a picture of the pipe and lighter, then called [Program Manager]...." Staff #8's statement in the investigation indicated, "Stated he got to work at 9pm on 8/30/23. Stated he worked his shift and left [name of group home] around 9:20am on 8/31/23. Stated when he got home, he remembered he left the pipe and lighter in the bathroom. Stated he got back to the group home between 9:30am and 9:45am. Stated he went into the home, went to the bathroom, got the pipe and lighter, and then he left. Stated he did not mean to bring the pipe into the home. Stated he had been in a hurry when he got out of his car and accidentally picked up the pipe. Stated it fell out of his pocket in the bathroom, and he laid it on the shelf and then forgot about it. Stated he did not use any drugs while on the job. Stated the pipe was a meth pipe." The investigation indicated, "...Conclusion: It is substantiated [staff #8] left a meth pipe and lighter on the bathroom shelf at [name of group home]. Addendum 10-2-23: It is substantiated [staff #8] violated Rescare Drug and Alcohol-Free Workplace Policy." Staff #8 was terminated on 10/2/23. -There was no documentation the results of the investigation were reported to the administrator within 5 working days. 3) A 10/24/23 Investigative Summary indicated, "On 10/14/23 at 12:46pm the clients of [name of group home] were outside, [client A] was upset because he forgot his book, staff asked him to wait a minute and they would go and get it. [Client A] then went over to [client G] and twisted his ear,			

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	he then reached over to [client D] and bent to fingers backward. Staff intervened and redirected [client A] back into the house and counseled him on not hurting his peers and using his coping skills when he becomes upset. Both [clients D and G] were checked out for any injuries and none were found." -The results of the investigation were not submitted to the administrator within 5 working days. 4) A 10/24/23 Investigation Summary indicated, "On 10/16/23 at 5:07pm the clients were eating dinner. [Client A] got done eating first and wanted to color using the dining room table. Staff asked him to wait until supper was over so he would have more room, since everyone else was still eating. [Client A] became upset, he reached over and pulled on [client H's] ear. Staff redirected [client A], staff counseled him on using his coping skills when he is upset. [Client H] was checked for injuries to his ears and none were found." -The results of the investigation were not submitted to the administrator within 5 working days. On 12/1/23 at 11:32 AM, the Quality Assurance Manager (QAM) indicated the timeframe for reporting the results of investigations to the administrator was 5 working days. On 12/1/23 at 11:32 AM, the Quality Assurance Coordinator (QAC) indicated the timeframe for reporting the results of investigations to the administrator was 5 working days. 9-3-2(a)			

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W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 7 of 20 incident/investigative reports reviewed affecting clients A, D, G and H, the facility failed to ensure appropriate corrective actions were implemented to address client A's aggression toward his peers, clients C, G and H's fear of client A and client A's skin picking after falls requiring trips to the emergency room to close the wounds he reopened. Findings include: On 12/1/23 at 9:18 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1A) A 10/24/23 Investigative Summary indicated, "On 10/14/23 at 12:46pm the clients of [name of group home] were outside, [client A] was upset because he forgot his book, staff asked him to wait a minute and they would go and get it. [Client A] then went over to [client G] and twisted his ear, he then reached over to [client D] and bent to fingers backward. Staff intervened and redirected [client A] back into the house and counseled him on not hurting his peers and using his coping skills when he becomes upset. Both [clients D and G] were checked out for any injuries and none were found." -There were no interviews with clients D and G. -The investigation indicated, "All plans, policy, and procedures were followed appropriately." The investigation failed to identify client A's Behavior Support Plan for physical aggression	W 0157	To correct the deficient practice, supervisory staff have been trained in reporting the results of an investigation to the administrator within 5 working days, and ensuring appropriate corrective actions are in place. Additional monitoring will be achieved by The QAM holding weekly QA meetings with individuals responsible for investigations to: assign investigations, ensure investigations are turned into the administrator within 5 working days, ensure investigations are thorough, and to ensure appropriate corrective actions are in place. The QAM will track all investigations and report to the ED any concerns. The peer review will meet to review all investigations for thoroughness, timely completion, and appropriate recommendations. Ongoing monitoring will be achieved by the quality and safety committee meeting to discuss previous investigations and recommendations for effectiveness, and patterns.	01/05/2024

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	not being implemented to prevent it from happening. On 12/1/23 at 11:32 AM, the Quality Assurance Coordinator (QAC) indicated staff should immediately notify the administrator of allegations of abuse. The QAC indicated the investigation was not thorough. She indicated the investigation should identify the staff present at the time of the incident and include interviews with all pertinent staff and clients. 1B) A 10/24/23 Investigation Summary indicated, "On 10/16/23 at 5:07pm the clients were eating dinner. [Client A] got done eating first and wanted to color using the dining room table. Staff asked him to wait until supper was over so he would have more room, since everyone else was still eating. [Client A] became upset, he reached over and pulled on [client H's] ear. Staff redirected [client A], staff counseled him on using his coping skills when he is upset. [Client H] was checked for injuries to his ears and none were found." -The investigation did not include an interview with client H or his peers. -The investigation indicated, "All plans, policy, and procedures were followed appropriately... Staff will continue to follow his HRC (Human rights committee) and guardian approved BSP (behavior support plan)." 1C) On 10/23/23 at 3:45 PM, the 10/24/23 BDS (Bureau of Disabilities Services) report indicated, "On 10/23/23 at 3:45pm [client A] came into the kitchen, he was yelling because he broke his plastic pumpkin and staff could not fix it. Staff tried to redirect him, and spend 1:1 (one on one)			

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	with him to help him calm down. [Client A] refused to be redirected, he went up to [client D] and pushed him. [Client D] was standing by a kitchen chair, staff kept him from falling completely over the chair. [Client A] realizing what he did, went straight to his room without staff directing him to, he stayed in his room until he calmed down. Staff talked to him after about being nice to his peers. [Client D] was checked for any injuries, a quarter sized bruise was found on [client D's] upper right arm where it hit the back of the chair...." -The 10/24/23 Investigation Summary contained the same information included in the 10/16/23. The investigation also included information regarding a client living in a different group home. There were no interviews with the staff and clients involved in the incident. On 11/30/23 at 2:13 PM, the QAC indicated prior to client A moving into the group home, she thought it was a good placement. The QAC indicated the group home was not used to behaviors. The QAC stated, "I think he'd be better off with higher functioning clients. The QAC indicated she was not aware of any of client A's peers being afraid of him and none of the clients act scared of him. On 11/30/23 at 2:36 PM, the Qualified Intellectual Disabilities Professional (QIDP) stated client A was admitted to a psychiatric hospital due to "things not going well." The QIDP indicated client A's behaviors were affecting the other clients: client C gets down and cries, client H biting his hand and points at client A, and client G staying close to the staff. The QIDP indicated the group home was calm before client A moved in.			

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	On 12/1/23 at 2:10 PM, the nurse stated it was "pretty calm at the home prior to when he (client A) moved in." The nurse indicated clients C and G have been affected the most by client A's presence in the home. The nurse indicated client C complained of stomach issues when client A was home with him. The nurse indicated client C was spending more time in his bedroom isolating himself from client A. The nurse indicated client G, when client A was having behaviors, would shake and cry. The nurse stated she "had to sit with him and pat him on the shoulder to comfort him." The nurse indicated while she was sitting with client G, he was pointing at client A indicating client A was bothering him. The nurse stated "Last week, [client G] was curled up in a ball upset and sad looking due to [client A]." The nurse indicated she observed client G on 11/30/23 while client A was in the psychiatric hospital and he was happy, excited, and seemed to be back to his normal self due to client A being gone. The nurse stated, "[Client A] is not appropriately placed at the group home." On 11/30/23 at 11:30 AM, staff #3 indicated she did not think client A was appropriately placed at the group home. Staff #3 stated client A was "not an appropriate fit for the home." Staff #3 stated client A "doesn't listen, yells and screams. Had the house in an uproar... [Client C] been upset, others as well. [Client A] has client to client (aggression) with [clients D, H and G]...." On 11/30/23 at 11:55 AM, the guardian for clients B, C, D and G indicated she had been concerned about the clients' safety and wellbeing since client A moved into the group home. The guardian indicated she called BDS, Program Manager and the QIDP to express her concerns but received no responses alleviating her concerns. The guardian			

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	indicated the BDS representative told her it was client A's home as well. The guardian indicated client C had been emotional since client A moved in. On 11/30/23 at 12:17 PM, staff #4 indicated client A was not appropriately placed at the group home. Staff #4 stated client A was OK for awhile but since then had "caused a lot of problems." Client H has been biting his hands. Client C has been crying and more emotional. Staff #4 stated client A moving in, "Changed the whole dynamics of the house... Ripple effect. Whole dynamics changed." On 11/30/23 at 12:33 PM, client G indicated client A bothered him. Client G, when asked if he was scared of client A, indicated yes. On 11/30/23 at 12:42 PM, client H indicated client A bothered him. Client H hit his hand when the surveyor asked him about client A. Client H touched his head and said yes when asked if he was scared of client A. On 11/30/23 at 12:46 PM, staff #3 indicated the staff working at the group home did not document client A's behaviors as they should have. Staff #3 indicated the staff was told client A had no maladaptive behaviors when he moved in. On 11/30/23 at 12:53 PM, staff #4 indicated there was one night (she did not recall the date) the overnight shift staff moved client A's roommate's bed out of their bedroom and into the kitchen due to client A's screaming and turning the lights on and off in the room. Staff #4 stated client A "turned the house upside down. Clients nervous and upset. [Client F's] rectal digging increased when [client A's] behaviors increased." Staff #4			

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	indicated since client A was in the psychiatric hospital, client C was much calmer, client H's hand biting decreased and client F was sleeping better. Staff #4 stated the home was "much calmer with [client A] gone." On 11/30/23 at 1:30 PM, client C stated "[Client A's] behaviors scare me. He got mad, angry, he hit me. Makes me nervous." Client C stated it was "a lot better with him gone. He bothers others as well. Everybody seems afraid of him. He's up all night. He falls a lot." 2A) On 11/3/23 at 5:42 AM, client A fell in his bedroom. The 11/3/23 BDS report indicated, "On 11/3/23 at 5:42am third shift staff was doing room checks. The staff reported that [client A] had already been up and had opened his door to his room a couple of times. Staff was going to check on him and his roommate. When staff opened the door, [client A] went to turn around and fell. He hit his head on the floor. Staff immediately went to [client A]. They asked him if he could set (sic) up, [client A] replied yes. Staff asked him if he hurt anywhere besides his head, [client A] replied no. Staff helped him up and to the couch, staff applied pressure to his head and called 911. Staff reported that [client A] had a 2" by 1cm (centimeter) cut on the left side of his forehead and it was bleeding. EMS (Emergency Medical Services) showed up and took [client A] to the hospital. The hospital did scans and everything came back negative. [Client A] was released at 10:45am. Staff is doing head tracking on him and will continue to monitor him." 2B) On 11/10/23 at 1:58 AM, client A exited his bedroom and his head was bleeding. The 11/10/23 BDS report indicated, "On 11/10/23 at 1:58am [client A] came out of his room, staff noticed that			

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	his head was bleeding. [Client A] had ripped his stitches from his fall on 11/3/23 (IR#1520852). Staff applied pressure to his head and called for an ambulance. EMS arrived at 2:08am, they assessed [client A] and left for the ER (emergency room) at 2:16am. The ER stitched his head again. The stitches will dissolve on their own in 3-8 days. The ER sent him home. Staff will follow the instructions that the ER put on his discharge paper. Keeping the laceration clean and dry, covered and they may apply bacitracin (antibiotic ointment). Staff will monitor [client A] to make sure that he is redirected from rubbing the laceration." On 11/30/23 at 12:45 PM, a focused review of client A's daily charting was conducted. An 11/30/23 note on the back of client A's behavior tracking sheet indicated, "Ripped open a wound on his forehead w/ (with) his fingers. Took to ER." An 11/13/23 Incident Follow-Up Report indicated, "Did the Individual rip his stitches intentionally or was it accidental? We believe it was accidental. His stitches were fine when he went to bed. Our nurse thinks that it was probably itching from the healing and he was rubbing or scratching it in his sleep." 2C) On 11/13/23 at 5:10 PM, client A fell in the dining room. The 11/14/23 BDS report indicated, "On 11/13/23 at 5:10pm [client A] got up from the dining room table. He picked up his plate and turned to take his plate to the sink, he lost his balance and fell backwards. He hit his head on the floor. The staff went to him and helped him sit up. They asked him if he could stand and he said yes. They helped him up and onto a chair. Staff checked his head, they found a 1" (inch) wound			

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	that was bleeding. Staff called the nurse, the nurse told staff to send him to the ER. Staff called for an ambulance. The EMS arrived and took [client A] to the ER. At the ER he received two staples to close his wound. He will have the staples removed in 10 days. He will follow up with [name of doctor] in 1 to 2 weeks...." The 11/16/23 Investigative Summary indicated, "[Client A] fell on 11.13.23 when getting up from the dining room table to take his plate to the sink. [Client A] stood up from the table, he went to turn and lost his balance and fell backwards. [Client A's] walker was behind his chair and available to him. [Client A] has a 1" wound on the back of his head. [Client A] received two staples to close the wound. According to discharge papers, the wound on [client A's] forehead from a previous incident was also treated. It was found he had picked out the stitches. The wound could not be stitched again, they cleaned it, bandaged it, and then wrapped his head so he could not pick at it. The wound on his forehead is infected. [Client A] was prescribed antibiotics by the ER doctor. No one noticed that his wound was infected. [Staff #2] was the staff on duty... Conclusion: It is substantiated risk plans were followed at the time [client A] fell on 11/13/23. Fall risk plan states that he should be encouraged to use his walker and staff are to help with ambulation when needed." On 12/1/23 at 12:58 PM, a focused review of client A's medical record was conducted. Client A's 11/13/23 Discharge Instructions indicated, "...Diagnosis from today's visit: Fall. Head injury. Laceration of head. Infected wound. Compulsive skin picking... What to do next: ...Keep forehead wound covered, do not allow picking. Strong head wrap dressing, knit hat or toboggan over dressing. Discuss hand mits (sic) with patient's			

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	PCP (primary care provider) if necessary. Antibiotics as prescribed. Clindamycin 300 mg (milligrams/antibiotic) three times a day for secondary wound infection due to self picking. Follow up with [name of doctor] to discuss possible repair or further wound care. Staples to posterior head lac (laceration) must stay covered as well. Do not allow picking. Staples need removed in 10 days...." 2D) On 11/21/23 at 10:20 PM, client A fell in his bedroom. The 11/22/23 BDS report indicated, "On 11/21/23 at 10:20pm staff heard [client A's] bedroom door open and then a thud. Staff was already on their way to his room. [Client A] had fell (sic). Staff helped him up and into the living room. They checked him over and found a knot forming on the back of his head. They called for an ambulance. The EMS (Emergency Medical Services) arrived and took [client A] to the ER. They did a CT (computed tomography)scan of his head and spine. All scans came back negative. He was discharged from the ER...." On 12/1/23 at 1:01 PM, a review of an interdisciplinary team meeting on 11/14/23 was conducted. The notes indicated, "...Staff report unsteadiness and that there were no falls prior to the new medication of Clonazepam and Ambien. The team does not believe the Ambien is a benefit. [Name of nurse] will inquire further with the doctor and advocate a D/C (discontinue) if appropriate. The team reviewed each of the falls and the factors surrounding the incidents. [Name of nurse] will continue to maintain contact with wound care. Hand mittens were proposed as a tool to help [client A's] injuries heal...." The IDT did not indicate whether or not the IDT agreed with the recommendation to use hand mitts. There was no documentation the IDT discussed a			

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	knit hat or toboggan. On 12/1/23 at 10:27 AM, a review of client A's risk plans and program plans was conducted. Client A did not have a plan for skin picking. There was no plan to keep client A's head covered. There was no plan for the use of a knit hat or toboggan. There was no plan for the use of hand mitts. On 12/5/23 at 9:09 AM, the nurse indicated she bought mittens and took them to the group home. The nurse indicated she did not think client A used the mittens due to his wounds being bandaged well. The nurse indicated client A wore a toboggan or a Santa Claus hat. The nurse stated "I didn't put in plan." The nurse indicated she was not aware of a plan to prevent client A from picking at his wounds. The nurse indicated there was no plan for mittens, hat and keeping his head covered to prevent him from picking. On 12/5/23 at 9:17 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated he left the IDT unclear whether or not the team agreed to the use of the mittens. The QIDP indicated he should have clarified whether or not the team agreed and documented it on the form. The QIDP indicated although interventions were put in place to prevent client A from picking at his wounds, there was no plan addressing the interventions. The QIDP indicated client A wore a hat and staff wrapped the wound better. The QIDP indicated there was no plan for skin picking, use of a hat, keeping his head covered and bandaging the wound. On 12/5/23 at 9:24 AM, the Associate Executive Director (AED) indicated there should have been a written plan developed for skin picking including keeping his head covered, wearing a			

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	hat, bandage and the use of mittens. This federal tag relates to complaint #IN00421880. 9-3-2(a)			
W 0227 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on record review and interview for 1 of 3 clients in the sample (A), the facility failed to ensure client A had a plan addressing picking at his head wounds after falls with injury. Findings include: On 12/1/23 at 9:18 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 11/3/23 at 5:42 AM, client A fell in his bedroom. The 11/3/23 Bureau of Disabilities Services (BDS) report indicated, "On 11/3/23 at 5:42am third shift staff was doing room checks. The staff reported that [client A] had already been up and had opened his door to his room a couple of times. Staff was going to check on him and his roommate. When staff opened the door, [client A] went to turn around and fell. He hit his head on the floor. Staff immediately went to [client A]. They asked him if he could set (sic) up, [client A] replied yes. Staff asked him if he hurt anywhere besides his head, [client A] replied no. Staff helped him up and to the couch, staff applied pressure to his head and called 911. Staff reported that [client A] had a 2" by 1cm (centimeter) cut on	W 0227	To correct the deficient practice, the Supervisory and Nursing team have been trained on ensuring appropriate plans are in place to meet client needs as well as following all medical recommendations. Additional monitoring will be achieved by the administrative team meeting daily to ensure the needs of each client are met. The LPN will review all recommendations weekly to ensure plans are created when needed. The Nursing manager will meet with the LPN weekly to discuss the medical needs of each client to ensure appropriate actions are being taken. Ongoing monitoring will be achieved by weekly nursing assessments as well as monthly record reviews to ensure client needs are met.	01/05/2024

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	the left side of his forehead and it was bleeding. EMS (Emergency Medical Services) showed up and took [client A] to the hospital. The hospital did scans and everything came back negative. [Client A] was released at 10:45am. Staff is doing head tracking on him and will continue to monitor him." 2) On 11/10/23 at 1:58 AM, client A exited his bedroom and his head was bleeding. The 11/10/23 BDS report indicated, "On 11/10/23 at 1:58am [client A] came out of his room, staff noticed that his head was bleeding. [Client A] had ripped his stitches from his fall on 11/3/23 (IR#1520852). Staff applied pressure to his head and called for an ambulance. EMS arrived at 2:08am, they assessed [client A] and left for the ER (emergency room) at 2:16am. The ER stitched his head again. The stitches will dissolve on their own in 3-8 days. The ER sent him home. Staff will follow the instructions that the ER put on his discharge paper. Keeping the laceration clean and dry, covered and they may apply bacitracin (antibiotic ointment). Staff will monitor [client A] to make sure that he is redirected from rubbing the laceration." On 11/30/23 at 12:45 PM, a focused review of client A's daily charting was conducted. An 11/30/23 note on the back of client A's behavior tracking sheet indicated, "Ripped open a wound on his forehead w/ (with) his fingers. Took to ER." An 11/13/23 Incident Follow-Up Report indicated, "Did the Individual rip his stitches intentionally or was it accidental? We believe it was accidental. His stitches were fine when he went to bed. Our nurse thinks that it was probably itching from the healing and he was rubbing or scratching it in his			

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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
	sleep." 3) On 11/13/23 at 5:10 PM, client A fell in the dining room. The 11/14/23 BDS report indicated, "On 11/13/23 at 5:10pm [client A] got up from the dining room table. He picked up his plate and turned to take his plate to the sink, he lost his balance and fell backwards. He hit his head on the floor. The staff went to him and helped him sit up. They asked him if he could stand and he said yes. They helped him up and onto a chair. Staff checked his head, they found a 1" (inch) wound that was bleeding. Staff called the nurse, the nurse told staff to send him to the ER. Staff called for an ambulance. The EMS arrived and took [client A] to the ER. At the ER he received two staples to close his wound. He will have the staples removed in 10 days. He will follow up with [name of doctor] in 1 to 2 weeks...." The 11/16/23 Investigative Summary indicated, "[Client A] fell on 11.13.23 when getting up from the dining room table to take his plate to the sink. [Client A] stood up from the table, he went to turn and lost his balance and fell backwards. [Client A's] walker was behind his chair and available to him. [Client A] has a 1" wound on the back of his head. [Client A] received two staples to close the wound. According to discharge papers, the wound on [client A's] forehead from a previous incident was also treated. It was found he had picked out the stitches. The wound could not be stitched again, they cleaned it, bandaged it, and then wrapped his head so he could not pick at it. The wound on his forehead is infected. [Client A] was prescribed antibiotics by the ER doctor. No one noticed that his wound was infected. [Staff #2] was the staff on duty... Conclusion: It is substantiated risk plans were followed at the time [client A] fell on 11/13/23. Fall risk plan states that			

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	15G194	A. BUILDING 00 B. WING	12/05/2023

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	he should be encouraged to use his walker and staff are to help with ambulation when needed." On 12/1/23 at 12:58 PM, a focused review of client A's medical record was conducted. Client A's 11/13/23 Discharge Instructions indicated, "...Diagnosis from today's visit: Fall. Head injury. Laceration of head. Infected wound. Compulsive skin picking... What to do next: ...Keep forehead wound covered, do not allow picking. Strong head wrap dressing, knit hat or toboggan over dressing. Discuss hand mits (sic) with patient's PCP (primary care provider) if necessary. Antibiotics as prescribed. Clindamycin 300 mg (milligrams/antibiotic) three times a day for secondary wound infection due to self picking. Follow up with [name of doctor] to discuss possible repair or further wound care. Staples to posterior head lac (laceration) must stay covered as well. Do not allow picking. Staples need removed in 10 days...." 4) On 11/21/23 at 10:20 PM, client A fell in his bedroom. The 11/22/23 BDS report indicated, "On 11/21/23 at 10:20pm staff heard [client A's] bedroom door open and then a thud. Staff was already on their way to his room. [Client A] had fell (sic). Staff helped him up and into the living room. They checked him over and found a knot forming on the back of his head. They called for an ambulance. The EMS (Emergency Medical Services) arrived and took [client A] to the ER. They did a CT (computed tomography)scan of his head and spine. All scans came back negative. He was discharged from the ER...." On 12/1/23 at 1:01 PM, a review of an interdisciplinary team meeting on 11/14/23 was conducted. The notes indicated, "...Staff report unsteadiness and that there were no falls prior to			

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	the new medications of Clonazepam and Ambien. The team does not believe the Ambien is a benefit. [Name of nurse] will inquire further with the doctor and advocate a D/C (discontinue) if appropriate. The team reviewed each of the falls and the factors surrounding the incidents. [Name of nurse] will continue to maintain contact with wound care. Hand mittens were proposed as a tool to help [client A's] injuries heal...." The IDT did not indicate whether or not the IDT agreed with the recommendation to use hand mitts. There was no documentation the IDT discussed a knit hat or toboggan. On 12/1/23 at 10:27 AM, a review of client A's risk plans and program plans was conducted. Client A did not have a plan for skin picking. There was no plan to keep client A's head covered. There was no plan for the use of a knit hat or toboggan. There was no plan for the use of hands mitts. On 12/5/23 at 9:09 AM, the nurse indicated she bought mittens and took them to the group home. The nurse indicated she did not think client A used the mittens due to his wounds being bandaged well. The nurse indicated client A wore a toboggan or a Santa Claus hat. The nurse stated "I didn't put in plan." The nurse indicated she was not aware of a plan to prevent client A from picking at his wounds. The nurse indicated there was no plan for mittens, hat and keeping his head covered to prevent him from picking. On 12/5/23 at 9:17 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated he left the IDT unclear whether or not the team agreed to the use of the mittens. The QIDP indicated he should have clarified whether or not the team agreed and documented it on the form. The QIDP indicated although interventions were put in place			

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	to prevent client A from picking at his wounds, there was no plan addressing the interventions. The QIDP indicated client A wore a hat and staff wrapped the wound better. The QIDP indicated there was no plan for skin picking, use of a hat, keeping his head covered and bandaging the wound. On 12/5/23 at 9:24 AM, the Associate Executive Director (AED) indicated there should have been a written plan developed for skin picking including keeping his head covered, wearing a hat, bandage and the use of mittens. This federal tag relates to complaint #IN00421880. 9-3-4(a)			
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. Based on observation, interview and record review for 2 of 5 non-sampled clients (D and F), the facility failed to ensure their program plans were implemented as written. Findings include: 1) On 11/30/23 from 11:40 AM to 1:16 PM, an observation was conducted at the group home. At 11:40 AM, client D was sitting at the dining room table eating lunch. Staff #3 and #4 were not sitting at the table with client D supervising him.	W 0249	To correct the deficient practice, all staff have been re-trained on all client meal plans and following plans as written. Additional monitoring will be achieved by the Administrators completing daily observations. The administrative team will review the observation schedule monthly for effectiveness and determine the frequency at that time. Ongoing monitoring will be completed by the	01/05/2024

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	At 11:46 AM, staff #4 left to go pick up clients B and H. At 11:50 AM, staff #3 was in the dining room however she was not prompting client D to take drinks. At 12:08 PM, client D continued to eat unsupervised. Client D took a drink and coughed several times. At 12:12 PM, staff #4 sat down to assist client D finish his lunch. During lunch, staff did not supervise client D at all times, ensure he alternated small bites with honey thickened liquids and ensure client D kept his chin up while taking bites. On 12/1/23 at 10:27 AM, a focused review of client D's 3/10/23 Dining Plan indicated, "...[Client D] needs assistance with making his plate and following portion control. Staff will ensure small bites alternating honey thick liquids and pureed. Staff will encourage [client D] to have chin up while taking bites...." Client D's 3/10/23 Choking Plan indicated, "...1. Staff will encourage [client D] to adhere to diet recommended by physician. 2. Staff will make sure [client D] is in upright 90 degrees position for all intake. 3. Staff will prepare meals according to a pureed low-fat high fiber diet with Honey-thick liquids during meals. 4. Staff will ensure [client D] is taking small bites and alternating to honey liquids. 5. Staff will ensure [client D's] chin is up while taking bites for correct eating technique. 6. Staff will prepare meds crushed in soft foods. 7. Staff will monitor for signs/symptoms of choking during all food intake such as coughing, facial redness, drooling, gagging. Signs to watch for if aspiration occurs: coughing, choking, throat clearing, gurgling or wet voice, residual food in mouth, regurgitation of food or fluid through nares, and difficulty breathing...." On 12/1/23 at 11:19 AM, the Quality Assurance		RM/AS/QIDP/LPN being in the home at least weekly observing, coaching, and training staff.	

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	Manager (QAM) indicated client D's plans should be implemented as written. On 12/1/23 at 2:09 PM, the nurse indicated client D should be supervised at all times during meals due to being aspiration and choking risks. The nurse indicated client D's plans should be implemented as written. 2) On 11/30/23 from 11:40 AM to 1:16 PM, an observation was conducted at the group home. Throughout the observation when staff and/or clients entered the restrooms, there was no audible alert notifying the staff someone entered the restroom. This affected client F who was present in the group home throughout the observation. On 12/4/23 at 11:26 AM, a focused review of client F's 1/6/23 Individualized Support Plan (ISP) indicated, "...Manner in which the right will be modified: Freedom from access to bathroom doors without alarms. Reason the modification is needed: He is in need of supervision while in bathroom due to flushing objects down the toilet...." On 12/1/23 at 11:32 AM, the QAM indicated there should be bathroom door alarms in use at the group home due to client F's behavior of stuffing and flushing items down the toilet. The QAM indicated client F's plan should be implemented as written. On 12/1/23 at 11:32 AM, the Quality Assurance Coordinator (QAC) indicated there should be bathroom door alarms in use at the group home due to client F's behavior of stuffing and flushing items down the toilet. The QAC indicated client F's plan should be implemented as written.			

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	On 12/1/23 at 2:07 PM, the nurse indicated there should be bathroom door alarms in use at the group home due to client F's behavior of stuffing and flushing items (washcloths, towels, paper towels, etc) down the toilet. The QAM indicated client F's plan should be implemented as written. 9-3-4(a)			