

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/16/2015
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NAME OF PROVIDER OR SUPPLIER TRANSITIONAL SERVICES SUB LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4812 W SR 45 BLOOMINGTON, IN 47401
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W 0000 Bldg. 00	<p>This visit was for an investigation of complaint #IN00180377.</p> <p>Complaint #IN00180377: Substantiated. Federal/state deficiencies related to the allegation are cited at W102, W104, W122, W149, W154, W157 and W186.</p> <p>Unrelated deficiencies cited.</p> <p>Dates of Survey: September 8, 9, 10, 11, 14, 15 and 16, 2015</p> <p>Facility number: 000823 Provider number: 15G304 AIM number: 100249090</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 9/21/15.</p>	W 0000		
W 0102 Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT</p> <p>The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on record review and interview for 7 of 7 clients living at the group home at</p>	W 0102	Training with staff was completed on 9/17/15 to review prevention of	10/16/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>the time of the incidents (A, B, C, E, F, G and H), the facility failed the meet the Condition of Participation: Governing Body. The governing body failed to implement its policies and procedures to prevent client to client abuse, ensure staff at the facility-operated day program received training on client A's program plans in order to prevent client A from stabbing staff with a knife, ensure staff was retrained following an incident after locking herself in a room at the facility-operated day program during client A's behavioral incident of stabbing staff with a knife, prevent client A from eloping from the group home, ensure staff did not leave the group home during a behavioral incident leading to property damage and client A eloping from the group home, ensure staff intervened when client A took other clients' medications after destroying the medication storage area, conduct thorough investigations, ensure an incident report was submitted to the Bureau of Developmental Disabilities Services in a timely manner and implement appropriate corrective actions to address the incidents.</p> <p>Findings include:</p> <p>1) Please refer to W104. For 7 of 7 clients living in the group home at the</p>		<p>client to client abuse. Additional training will be completed on 10/6/15 and 10/8/15 to ensure all staff in the group home and day program receive this training. Observations will be completed by supervisory staff at least three times per week (one of these being during weekend hours) for four weeks and then at least two times per week ongoing, to monitor that staff are following client plans and preventing client to client abuse.</p> <p>Supervisory staff will be trained on completing client specific training for all new clients prior to their start in the group home and / or day program. This training will also consist of completing documented training with staff on any updates to client plans as they occur. Program Directors (QIDP) will review and approve that training is completed prior to direct support staff working a scheduled shift.</p> <p>Supervisory staff will be retrained on completing any necessary training with direct support staff following incidents of client aggression, client injury or other incidents where a review is needed or changes to a client's plan is made. This training with direct support staff will be completed in a timely manner following the incident. Area Director will review with Program Directors (QIDP) weekly all incidents and any recommendations</p>	

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	<p>time of the incidents (A, B, C, E, F, G and H), the governing body failed to exercise operating direction over the facility by failing to ensure thorough investigations were conducted, appropriate corrective actions were taken, staff was trained on client A's program plans at the day program, there was sufficient staff to manage and supervise the clients at the group home and an incident was reported to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner. The governing body failed to ensure investigations indicated whether or not abuse and neglect was substantiated. The governing body failed to ensure staff prevented client to client abuse.</p> <p>2) Please refer to W122. For 8 of 8 incident/investigative reports reviewed affecting clients A, B, C, E, F, G and H, the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement its policies and procedures to prevent client to client abuse, ensure staff at the facility-operated day program received training on client A's program plans in order to prevent client A from stabbing staff with a knife, ensure staff was retrained following an incident after locking herself in a room at the facility-operated day program during client A's behavioral incident of stabbing</p>		<p>from incidents and / or investigations and ensure that training for direct support staff is completed as needed.</p> <p>Group home staff will all be retrained on client specific plans and staff will receive disciplinary action as necessary if determined that plans are not followed for client protections. Observations will be completed by supervisory staff at least three times per week (one of these being during weekend hours) for four weeks and then at least two times per week ongoing, to monitor that staff are following client plans and preventing client to client abuse.</p> <p>Program Directors (QIDP) will be retrained on Internal Investigation Procedures, including what requires an investigation, who is interviewed, what documents should be reviewed, gathering all pertinent information, listing the specific conclusion for the investigation, determining any corrective action required and completing follow up as needed.</p> <p>Area Director and / or Quality Assurance Specialist will review all investigations upon completion to review for required (retrained) content.</p> <p>Program Directors (QIDP) will be retrained on completing BDDS reports in a timely manner and</p>	

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W 0104 Bldg. 00	<p>staff with a knife, prevent client A from eloping from the group home, ensure staff did not leave the group home during a behavioral incident leading to property damage and client A eloping from the group home, ensure staff intervened when client A took other clients' medications after destroying the medication storage area, conduct thorough investigations, ensure an incident report was submitted to the Bureau of Developmental Disabilities Services in a timely manner and implement appropriate corrective actions to address the incidents.</p> <p>This federal tag relates to complaint #IN00180377.</p> <p>9-3-1(a)</p> <p>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 7 of 7 clients living in the group home at the time of the incidents (A, B, C, E, F, G and H), the governing body failed to exercise operating direction over the</p>	W 0104	<p>implementing appropriate corrective actions to address the incidents. Area Director will review with Program Directors (QIDP) weekly all incidents to ensure that they are completed timely. Corrective action will be completed as necessary.</p> <p>Training with staff was completed on 9/17/15 to review prevention of client to client abuse. Additional training will be completed on 10/6/15 and 10/8/15 to ensure all staff in the group home and day</p>	10/16/2015

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	<p>facility by failing to ensure thorough investigations were conducted, appropriate corrective actions were taken, staff was trained on client A's program plans at the day program, there was sufficient staff to manage and supervise the clients at the group home and an incident was reported to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner. The governing body failed to ensure investigations indicated whether or not abuse and neglect was substantiated. The governing body failed to ensure staff prevented client to client abuse.</p> <p>Findings include:</p> <p>1) Please refer to W149. For 8 of 8 incident/investigative reports reviewed affecting clients A, B, C, E, F, G and H, the facility's governing body neglected to implement its policies and procedures to prevent client to client abuse, ensure staff at the facility-operated day program received training on client A's program plans in order to prevent client A from stabbing staff with a knife, ensure staff was retrained following an incident after locking herself in a room at the facility-operated day program during client A's behavioral incident of stabbing staff with a knife, prevent client A from eloping from the group home, ensure</p>		<p>program receive this training. Observations will be completed by supervisory staff at least three times per week (one of these being during weekend hours) for four weeks and then at least two times per week ongoing, to monitor that staff are following client plans and preventing client to client abuse.</p> <p>Supervisory staff will be trained on completing client specific training for all new clients prior to their start in the group home and / or day program. This training will also consist of completing documented training with staff on any updates to client plans as they occur. Program Directors (QIDP) will review and approve that training is completed prior to direct support staff working a scheduled shift. Program Directors (QIDP) will be retrained on Internal Investigation Procedures, including what requires an investigation, who is interviewed, what documents should be reviewed, gathering all pertinent information, listing the specific conclusion for the investigation, determining any corrective action required and completing follow up as needed. Area Director and / or Quality Assurance Specialist will review all investigations upon completion to review for required (retrained) content.</p> <p>Program Directors (QIDP) will be</p>	

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	<p>staff did not leave the group home during a behavioral incident leading to property damage and client A eloping from the group home, ensure staff intervened when client A took other clients' medications after destroying the medication storage area, conduct thorough investigations, ensure an incident report was submitted to the Bureau of Developmental Disabilities Services in a timely manner and implement appropriate corrective actions to address the incidents.</p> <p>2) Please refer to W153. For 1 of 8 incident reports reviewed affecting client A, the facility's governing body failed to ensure an incident report was submitted to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>3) Please refer to W154. For 8 of 8 incident/investigative reports reviewed affecting clients A, B, C, E, F, G and H, the facility's governing body failed to ensure thorough investigations were conducted.</p> <p>4) Please refer to W157. For 6 of 8 incident/investigative reports reviewed affecting clients A, B, C, E, F, G and H, the facility's governing body failed to ensure appropriate corrective actions</p>		<p>retrained on completing BDDS reports in a timely manner and implementing appropriate corrective actions to address the incidents.</p> <p>Area Director will review with Program Directors (QIDP) weekly all incidents to ensure that they are completed timely. Corrective action will be completed as necessary.</p> <p>Program Coordinators (formerly Home Managers) will be trained to send weekly schedules to Program Directors (QIDP) for review prior to the work week to ensure appropriate staffing ratios are scheduled for the homes.</p> <p>Training with direct support staff will be completed to review appropriate staffing ratios and their responsibility for changing home activities as needed to ensure appropriate staffing ratios are maintained.</p> <p>Observations will be completed by supervisory staff at least three times per week (one of these being during weekend hours) for four weeks and then at least two times per week ongoing, to monitor that staffing ratios are appropriate to meet clients' needs.</p>	

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W 0122 Bldg. 00	<p>were implemented.</p> <p>5) Please refer to W186. For 7 of 7 clients living at the group home at the time of the incident (A, B, C, E, F, G and H), the facility's governing body failed to ensure sufficient direct care staff was provided to manage and supervise the clients in accordance with their individual program plans.</p> <p>6) Please refer to W189. For 7 of 7 clients living at the group home at the time of the incident (A, B, C, E, F, G and H), the facility's governing body failed to ensure the facility-operated staff was trained prior to the incident and trained following a stabbing incident at the facility-operated day program.</p> <p>This federal tag relates to complaint #IN00180377.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview for 8 of 8 incident/investigative reports reviewed affecting clients A, B, C, E, F,</p>	W 0122	Training with staff was completed on 9/17/15 to review prevention of client to client abuse. Additional training will be completed on	10/16/2015			

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	<p>G and H, the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement its policies and procedures to prevent client to client abuse, ensure staff at the facility-operated day program received training on client A's program plans in order to prevent client A from stabbing staff with a knife, ensure staff was retrained following an incident after locking herself in a room at the facility-operated day program during client A's behavioral incident of stabbing staff with a knife, prevent client A from eloping from the group home, ensure staff did not leave the group home during a behavioral incident leading to property damage and client A eloping from the group home, ensure staff intervened when client A took other clients' medications after destroying the medication storage area, conduct thorough investigations, ensure an incident report was submitted to the Bureau of Developmental Disabilities Services in a timely manner and implement appropriate corrective actions to address the incidents.</p> <p>Findings include:</p> <p>1) Please refer to W149. For 8 of 8 incident/investigative reports reviewed affecting clients A, B, C, E, F, G and H,</p>		<p>10/6/15 and 10/8/15 to ensure all staff in the group home and day program receive this training. Observations will be completed by supervisory staff at least three times per week (one of these being during weekend hours) for four weeks and then at least two times per week ongoing, to monitor that staff are following client plans and preventing client to client abuse.</p> <p>Supervisory staff will be trained on completing client specific training for all new clients prior to their start in the group home and / or day program. This training will also consist of completing documented training with staff on any updates to client plans as they occur. Program Directors (QIDP) will review and approve that training is completed prior to direct support staff working a scheduled shift.</p> <p>Supervisory staff will be retrained on completing any necessary training with direct support staff following incidents of client aggression, client injury or other incidents where a review is needed or changes to a client's plan is made. This training with direct support staff will be completed in a timely manner following the incident. Area Director will review with Program Directors (QIDP) weekly all incidents and any recommendations from incidents and / or investigations and ensure that</p>	

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	<p>the facility neglected to implement its policies and procedures to prevent client to client abuse, ensure staff at the facility-operated day program received training on client A's program plans in order to prevent client A from stabbing staff with a knife, ensure staff was retrained following an incident after locking herself in a room at the facility-operated day program during client A's behavioral incident of stabbing staff with a knife, prevent client A from eloping from the group home, ensure staff did not leave the group home during a behavioral incident leading to property damage and client A eloping from the group home, ensure staff intervened when client A took other clients' medications after destroying the medication storage area, conduct thorough investigations, ensure an incident report was submitted to the Bureau of Developmental Disabilities Services in a timely manner and implement appropriate corrective actions to address the incidents.</p> <p>2) Please refer to W153. For 1 of 8 incident reports reviewed affecting client A, the facility failed to submit an incident report to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p>		<p>training for direct support staff is completed as needed.</p> <p>Group home staff will all be retrained on client specific plans and staff will receive disciplinary action as necessary if determined that plans are not followed for client protections.</p> <p>Observations will be completed by supervisory staff at least three times per week (one of these being during weekend hours) for four weeks and then at least two times per week ongoing, to monitor that staff are following client plans and preventing client to client abuse.</p> <p>Program Directors (QIDP) will be retrained on Internal Investigation Procedures, including what requires an investigation, who is interviewed, what documents should be reviewed, gathering all pertinent information, listing the specific conclusion for the investigation, determining any corrective action required and completing follow up as needed.</p> <p>Area Director and / or Quality Assurance Specialist will review all investigations upon completion to review for required (retrained) content.</p> <p>Program Directors (QIDP) will be retrained on completing BDDS reports in a timely manner and implementing appropriate corrective actions to address the incidents.</p>	

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	<p>3) Please refer to W154. For 8 of 8 incident/investigative reports reviewed affecting clients A, B, C, E, F, G and H, the facility failed to conduct thorough investigations.</p> <p>4) Please refer to W157. For 6 of 8 incident/investigative reports reviewed affecting clients A, B, C, E, F, G and H, the facility failed to ensure appropriate corrective actions were implemented.</p> <p>5) Please refer to W186. For 7 of 7 clients living at the group home at the time of the incident (A, B, C, E, F, G and H), the facility failed to provide sufficient direct care staff to manage and supervise the clients in accordance with their individual program plans.</p> <p>6) Please refer to W189. For 7 of 7 clients living at the group home at the time of the incident (A, B, C, E, F, G and H), the facility failed to ensure the facility-operated staff was trained prior to the incident and trained following a stabbing incident at the facility-operated day program.</p> <p>This federal tag relates to complaint #IN00180377.</p> <p>9-3-2(a)</p>		Area Director will review with Program Directors (QIDP) weekly all incidents to ensure that they are completed timely. Corrective action will be completed as necessary.		

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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 8 of 8 incident/investigative reports reviewed affecting clients A, B, C, E, F, G and H, the facility neglected to implement its policies and procedures to prevent client to client abuse, ensure staff at the facility-operated day program received training on client A's program plans in order to prevent client A from stabbing staff with a knife, ensure staff was retrained following an incident after locking herself in a room at the facility-operated day program during client A's behavioral incident of stabbing staff with a knife, prevent client A from eloping from the group home, ensure staff did not leave the group home during a behavioral incident leading to property damage and client A eloping from the group home, ensure staff intervened when client A took other clients' medications after destroying the medication storage area, conduct thorough investigations, ensure an incident report was submitted to the Bureau of Developmental Disabilities Services in a timely manner and implement appropriate corrective actions	W 0149	Training with staff was completed on 9/17/15 to review prevention of client to client abuse. Additional training will be completed on 10/6/15 and 10/8/15 to ensure all staff in the group home and day program receive this training. Observations will be completed by supervisory staff at least three times per week (one of these being during weekend hours) for four weeks and then at least two times per week ongoing, to monitor that staff are following client plans and preventing client to client abuse. Supervisory staff will be trained on completing client specific training for all new clients prior to their start in the group home and / or day program. This training will also consist of completing documented training with staff on any updates to client plans as they occur. Program Directors (QIDP) will review and approve that training is completed prior to direct support staff working a scheduled shift. Supervisory staff will be retrained on completing any necessary training with direct support staff following incidents of client aggression, client	10/16/2015

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	<p>to address the incidents.</p> <p>Findings include:</p> <p>On 9/8/15 at 11:56 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 8/14/15 at 9:00 AM, the Bureau of Developmental Disabilities Services (BDDS) incident report for the facility-operated day program, dated 8/14/15, indicated, "At 9:00 am [client A] became upset before leaving for an outing because he was not allowed to sit by his girlfriend in the very backseat of the van. He continued to escalate and went to the front office where he pulled a knife out of his pocket and held it to his stomach saying that he was going to kill himself. [Day Program (DP) staff #1] was trying to calm him down when [client A] took the knife and stabbed [DP staff #1] in the upper right shoulder. The police were called and [client A] was handcuffed and taken to jail. [DP staff #1] had 7 sutures inside the wound and 11 sutures to close the wound and the knife nicked the bone. [Client A's] IDT (interdisciplinary team) will be meeting on 8/18/15. Staff will continue to follow policy and procedure (sic) to ensure the health and safety of all clients."</p>		<p>injury or other incidents where a review is needed or changes to a client's plan is made. This training with direct support staff will be completed in a timely manner following the incident.</p> <p>Area Director will review with Program Directors (QIDP) weekly all incidents and any recommendations from incidents and / or investigations and ensure that training for direct support staff is completed as needed.</p> <p>Group home staff will all be retrained on client specific plans and staff will receive disciplinary action as necessary if determined that plans are not followed for client protections.</p> <p>Observations will be completed by supervisory staff at least three times per week (one of these being during weekend hours) for four weeks and then at least two times per week ongoing, to monitor that staff are following client plans and preventing client to client abuse.</p> <p>Program Directors (QIDP) will be retrained on completing BDDS reports in a timely manner and implementing appropriate corrective actions to address the incidents.</p> <p>Area Director will review with Program Directors (QIDP) weekly all incidents to ensure that they are completed timely. Corrective action will be completed as necessary.</p>	

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	<p>The investigation, dated 8/21/15, indicated in Day Program Staff (DPS) #2's interview, in part, "[DPS #2] stated that she told [DPS #3] 'privately' that [client A] and another female client [initials] aren't supposed to sit next to each other in the van. [DPS #2] stated that she heard [DPS #3] tell [client A] that he couldn't sit next to [client A's girlfriend's initials] in the van and he then came 'storming over' to her while she was putting client lunches in the refrigerator and 'picked me up and slammed me into the refrigerator hard.' [DPS #2] stated that she was able to get to a chair and sit down but that [client A] had gone out the door of the day program and into the office door. She stated that she saw him coming back and went toward the hallway and [client A] blocked her and [DPS #3's] way into the med room and so she went to the music room because she felt he was 'looking at me' and 'targeting me.' [DPS #2] stated that she and [DPS #4] had several clients in the music room with them with the door closed until [client A] went back to the big day program room. She stated that she and [DPS #3] went back into the big day program room and [client A] went outside and began to throw rocks at the windows. [DPS #2] stated that she moved clients away from the windows to</p>			
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	<p>the back of the room in case the windows were to break. She stated that she began moving clients to the music room and [DPS #3] and [staff from another provider] told her to get into the room with the clients so that [client A] wouldn't try to hurt her again. [DPS #2] stated that when she came out of the music room again, she saw [DPS #1] outside with [client A] and she saw [client A] with a 'shiny thing pointed at his stomach.' She stated that she and [DPS #5] were in the big room with clients at that time and so she went to the med room to get clients their cigarettes and locked herself in the room (without any clients) and called [name of Day Program Coordinator] (PC for day program who was off work on this day) to report what was happening. [DPS #2] stated that she was in there 'quite some time' and then heard someone say that [DPS #1] had gotten hurt so she came out of the room... [DPS #2] stated that when she came out of the med room, she found that the police were there and wanted to talk to her...."</p> <p>The Conclusion section of the investigation indicated, "[Client A] had behaviors in the day program that resulted in an injury to staff." The investigation indicated, in part, "Staff interviewed stated that [name of client</p>			

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	<p>A's girlfriend] seating arrangement plan to sit in the front seat on outings is a verbal instruction. No written documentation was found to support this plan or to support that all staff have been trained on this plan." There was no documentation in the investigation indicating the corrective actions the facility implemented to address the lack of a written plan or training staff on the plan. There was no documentation the facility took action with DPS #2 who had locked herself, without any clients, in the medication room during part of the incident. The investigation did not indicate whether or not the staff implemented client A's program plan as written. The investigation did not address how client A was in possession of a knife. The investigation did not include an interview or an attempted interview with client A.</p> <p>On 9/8/15 at 2:06 PM, a review of client A's record was conducted. Client A's 5/13/15 Individualized Support Plan (ISP) indicated, in part, "[Client A] has diagnoses of Intermittent Explosive Disorder, Sexual Abuse of a Child, and Oppositional Defiance Disorder. [Client A] displays behaviors such as property destruction, physical aggression, self-injurious behavior, elopement, and sexual acting out." The ISP indicated,</p>			

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	<p>"Assessment of his/her supervision needs: Requires 24 hour supervision."</p> <p>Client A's Behavior Support Plan, dated 5/6/15, indicated he had the following targeted behaviors: physical aggression, injurious to self/suicidal ideation, absent without notification or permission, resistance to instruction and property destruction. The BSP indicated, "[Client A's] team will secure a psychiatric referral within 30 days...." There was no documentation of a psychiatric referral in client A's record for review. Client A had a counseling appointment on 8/4/15. The BSP had a note, dated 8/18/15, "All sharp objects must be kept in a locked container with staff only having access to the container due to several instances of property destruction using sharp objects, claims of suicidal thoughts and, physical aggression toward others using sharp objects."</p> <p>On 9/8/15 at 2:13 PM, the nurse indicated client A did not have a psychiatric evaluation since he was admitted on 4/10/15. The nurse indicated due to client A's history the facility was having a difficult time finding a psychiatrist to see him. The nurse indicated an appointment was made with a psychiatrist but the appointment was not held due to client A being in the</p>			

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	<p>hospital at the time of the appointment. The appointment was rescheduled but not held due to client A being arrested.</p> <p>On 9/8/15 at 12:17 PM, the Area Director (AD) indicated the incident started when client A was told he could not sit in the back of the van with his girlfriend. The AD indicated the incident could have been avoided if the staff at the day program had put client A on the phone with him (client A was asking to speak to the AD) and staff stayed out of arm's length of client A. The AD indicated there was no plan for client A's girlfriend to sit in the front seat of the van. The AD indicated the staff could have sat in the back of the van with the clients. The AD stated, "the whole thing could have been avoided." The AD indicated the investigation did not address where the knife was obtained. The AD indicated client A told the AD he got the knife from a friend. The AD indicated he thought client A obtained the knife from his uncle. The AD indicated none of the staff, prior to the incident, was aware he had a knife. The AD indicated the stabbing was witnessed by the Program Director and the receptionist. The AD indicated client A had been in jail since the incident and there was no plan of returning client A to the group home or the day program.</p>			

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	<p>On 9/8/15 at 4:46 PM, the PD indicated following the incident, client A's team met to discuss sharps, keeping staff and clients safe and they added advanced restraint techniques to client A's plan. The PD indicated she was unsure, following the incident, if client A's girlfriend's plan was revised to include a plan for her to only sit in the front of the van. The PD indicated his girlfriend's plan should have been revised to ensure consistency. On 9/10/15 at 11:10 AM, the PD indicated the staff was not retrained following the incident. The PD indicated staff was trained on workplace violence following the incident however the training was already scheduled and not in response to the incident. The PD indicated she and the AD spoke to client A following the incident and prior to his arrest. The PD indicated she did not document her interview with client A but should have.</p> <p>On 9/10/15 at 10:41 AM, Day Program Staff (DPS) #2 indicated the incident started when client A wanted to sit by his girlfriend on the van. DPS #2 indicated client A knew he should not sit with her and his girlfriend told him he knew the rules. DPS #2 indicated DPS #3 told client A he could not sit next to his girlfriend. Client A picked her up with</p>			

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	<p>one hand and threw her against the refrigerator knocking the wind out of her. Client A started throwing rocks at the windows from the outside. She assisted the clients to move away from the windows and into the smaller program areas. DPS #2 stated a staff from another provider "shoved" her into the music room and told her not to come out since client A was targeting her. DPS #2 indicated she left the music room to get cigarettes from the medication room since she thought client A had calmed down. DPS #2 indicated the same staff from another provider told her not to come out. DPS #2 indicated she stayed in the locked room by herself until the police came. DPS #2 stated, "I was terrified."</p> <p>On 9/10/15 at 11:10 AM, the Day Program Program Director (DPPD) indicated client A's girlfriend had an unwritten rule for her to sit in the front seat of the van due to inappropriate touching. The DPPD indicated, initially, he had the day program staff's training documentation on client A's plans. The DPPD indicated he was unable to locate the documentation.</p> <p>The DPPD indicated he was not aware DPS #2 locked herself in the medication room during the incident. The DPPD</p>			

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	<p>indicated DPS #2 needed to be retrained on what to do and where to go during an incident.</p> <p>On 9/10/15 at 11:10 AM, Quality Assurance Specialist (QAS) indicated DPS #2 told her during the investigation that client A was targeting her. The QAS indicated at one point, DPS #2 was in the music room with several clients but left the area to get cigarettes for the clients. The DPS #2 indicated client A was targeting her so she locked herself in the medication room and stayed in there for quite a while. The QAS indicated the facility should have implemented corrective action with DPS #2 for locking herself in a room during the incident. The QAS indicated she did not indicate in the investigation whether or not staff implemented client A's plan as written. The QAS indicated she thought the staff implemented the plan as written after reviewing the plan. The QAS indicated the staff offered other activities and used the least restrictive interventions. The QAS indicated the investigation should have addressed whether or not the staff implemented the plan. The QAS indicated although she did not document her attempts to find out how client A obtained the knife, she indicated she contacted the Program Coordinator (PC). The QAS indicated she was unable to</p>			

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	<p>figure out where the knife came from. The QAS indicated this information should have been included in the investigation. The QAS indicated following the incident, client A went to jail. The QAS indicated she did not attempt to interview client A for the investigation.</p> <p>On 9/10/15 at 11:10 AM, the PC indicated she checked with client C's guardian (client C had several knives given to him after his father passed away) and all of client C's knives were accounted for. The PC indicated someone in client A's family could have given him the knife when he went to visit them.</p> <p>2) On 8/11/15 at 8:10 PM, the on-call PD received a call of an incident involving client A. The BDDS incident report indicated, in part, "[Client A] was upset about a situation involving an outing. [Client A] became physically aggressive and was throwing rocks at staff and then threw a rock at the rear window of the group home van causing the window to break. [Client A's] behavior continued to escalate as staff was attempting to verbally redirect him. [Client A] returned back inside to the group home and went to his room. [Client A] had retrieved a fishing tool</p>			

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	<p>from his tackle box and took the tool back outside and damaged the tires of one of the staff's vehicles. Staff contacted the police for assistance due to [client A's] behavior continuing to escalate. After damaging the tires [client A] eloped from the group home. Staff were unable to follow him due to having to stay at the home as there were other residents in the home. Police arrived at the home and staff informed them that [client A] had eloped and that he had a tool, which he had damaged staff's tires with. Police went and looked for [client A] and found him and took him to [name of hospital] for evaluation. [Client A] was released from [name of hospital] at approximately 3 am and on call program coordinator, [name], picked [client A] up from the hospital and he returned to the group home." This affected clients B, C, E, F, G and H.</p> <p>The investigation, dated 8/17/15, indicated the facility was investigating an incident of elopement, property damage and client A being admitted to the hospital. There was no documentation in the investigation indicating whether or not the facility investigation substantiated or unsubstantiated neglect. The interview with staff #10 in the investigation indicated client A was upset due to not being able to go fishing with client E.</p>			

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	<p>Staff #10 indicated staff #11 left the group home with client E and client A wanted to go. Staff #10 indicated client A threw a rock at the van and staff #11 kept driving. Staff #10 stated in the investigation, "he couldn't remember what happened after that. Claimed that he 'blacked out.'" Staff #11's interview in the investigation indicated client E was scheduled to go on a one on one outing and client E wanted to go fishing. Staff #11 indicated client E did not want client A to go fishing with him. Staff #11 observed client A coming toward the van with a rock. Client A hit the van and broke the window with the rock. Staff #11 indicated he left the group home to go to the park to locate the AD for assistance. Staff #3 indicated in the investigation staff #11 was leaving with client E. Client A was upset and went outside. Client A picked up a rock and threw it at the van. Client A went to his room and got a tool to flatten staff #11's tires. Staff #3 attempted to contact the Home Manager and did not reach her. Staff #3 indicated she called the police when she could not locate client A. The Conclusion of the investigation indicated, "Evidence supports staff did not intervene appropriately." The Recommendations section indicated, "In order to prevent the likelihood of future occurrence, staff will discuss how to</p>			

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	<p>effectively manage [client A's] behaviors at the next staff meeting. If [client A] is having a behavior, one staff person is not to leave the other staff alone with him and other clients. They need to assist until the situation has been deescalated."</p> <p>There was no documentation in the investigation indicating corrective action was implemented with staff #11. There was no documentation of a staff meeting. There was no documentation staff was retrained. There was no documentation in the investigation the facility did not have sufficient staff at the time of the incident. There was no documentation indicating how long it took the police to locate client A and where he was located.</p> <p>On 9/8/15 at 4:08 PM, staff #3 indicated she took client A to his football practice and when client A returned to the group home, he took staff #6's keys to her vehicle and stole her cigarettes. Client A then wanted to go with client E on his outing. Client E told client A he wanted to go by himself. Client A got mad and went outside. Staff #3 indicated she asked staff #11 to stay at the group home and not leave with client E. Staff #3 indicated client A ran toward her and she ran around the van several times to stay away from client A as staff #11 and client E were in the van. Staff #3 indicated</p>			

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	<p>staff #11 told her to get in the van. Staff #3 indicated she ran to the front of the van and was looking underneath the van to see where client A was located. Staff #3 stated client A "bashed in" the window with a grill brush. Staff #3 indicated staff #11 asked her to move so he could leave in the van. Staff #3 indicated she got client G and assisted him into the group home as client A chased them. Staff #3 indicated she called the Area Director. Staff #3 indicated she got the other clients out of the house. Staff #3 indicated she did not know where client A was at the time. Staff #3 indicated client A used a tool to stab staff #11's tires and broke out his windows. Staff #3 indicated she called the police. Staff #3 indicated when she turned around client A was gone. Staff #3 indicated she did not know where he was located or how long it took to locate him.</p> <p>On 9/8/15 at 12:53 PM, the Area Director (AD) indicated client A required 24 hour supervision. The AD stated staff #3 was "negligent." On 9/8/15 at 1:02 PM, the AD indicated there was one staff at the group home at the time client A eloped. The AD indicated the second staff took client E to go fishing. The AD indicated he went to the house after the incident was over. The AD indicated the clients</p>			

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	<p>at the group home were aware of what occurred (throwing rocks, flattening staff's tires) but staff #3 did not know. The AD indicated staff #3 should have kept client A in line of sight. The AD indicated staff #3 contacted him and at the time did not know where client A was located. The AD indicated staff #3 was at the home with client A and 5 additional clients. The AD indicated client A had just returned to the group home from football practice. Client A wanted to go fishing with client E but client E did not want client A to go with him. The AD indicated client E skipped football practice and should not have been taken fishing. The AD stated the staff "rewarded" client E by taking him fishing even though he skipped practice. The AD indicated there was no plan to keep client E home if he skipped practice but if he indicated he could not practice then the staff should not have taken him fishing. The AD indicated client A used a multitool to let the air out of staff's tires and break his window. The AD stated staff #3 was "freaking out" while talking to him on the phone even when client A was outside the group home. The AD indicated the staff needed to stay calm during incidents. The AD indicated staff #11 took client E to the park to look for the AD. The AD stated staff #11 should have "never left the house" when the</p>			

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	<p>situation was going on. The AD indicated staff #11 was driving the group home van when client A threw a rock at the van and broke the window. The AD indicated staff #11 knew there was an incident occurring at the group home when he left. The AD indicated one staff was sufficient to implement the clients' plans.</p> <p>On 9/8/15 at 1:30 PM, the Program Director (PD) indicated client A required 24 hour supervision. The PD stated it was "neglect." The PD indicated staff #3 should have kept client A within line of sight. On 9/8/15 at 4:46 PM, the PD indicated the investigation did not indicate how long client A was unsupervised and it should have been included. The PD indicated staff #11 left the group home with client E during the incident to find the Area Director for assistance. The PD indicated staff #11 should not have left the group home during the incident. The PD indicated there was no corrective action taken with staff #11 for leaving the group home during an incident. The PD stated, "In hindsight, I should have completed corrective action." The PD stated, "there should have been another staff here since there was a planned outing (with client E)." The PD indicated there was insufficient staff at the group home at the</p>			

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	<p>time of the incident.</p> <p>On 9/10/15 at 11:10 AM, the PC indicated client A's theft of cigarettes occurred prior to him leaving for football practice. The PC indicated she was unsure how client A entered the staff's vehicle to get the cigarettes. The PC indicated there was no corrective or disciplinary action taken with staff #11 who left during the incident. The PC indicated staff #11 should have received corrective action.</p> <p>On 9/10/15 at 11:10 AM, the PD indicated she was aware client A had stolen cigarettes from a staff's vehicle. The PD indicated the staff was not trained to lock their vehicles. The PD indicated there was no corrective or disciplinary action taken with staff #11 for leaving in the middle of an incident. The PD indicated the facility should have taken corrective action with staff #11. The PD indicated a staff meeting was held on 8/26/15 to discuss the incident. The PD indicated the 8/26/15 staff meeting included retraining the staff. The PD indicated there was sufficient staff at the home until staff #11 left the home with client E. The PD indicated the staffing level at the home was 1 staff to 4 clients. The PD indicated the investigation should have indicated there</p>			

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	<p>was insufficient staff at the group home when staff #11 left with client E. The PD indicated the investigation should have indicated how long client A was unsupervised. The PD indicated he was unsupervised for 17 minutes.</p> <p>On 9/10/15 at 11:10 AM, the QAS stated staff #11 leaving during the incident was "neglect."</p> <p>On 9/10/15 at 11:10 AM, the DPPD indicated something should have been done with staff #11 for leaving during the incident. The DPPD stated, "it was neglect."</p> <p>3) On 8/10/15 at 2:00 PM at the facility-operated day program, client A became upset due to not liking the cigarettes the group home sent for him. The BDDS report, dated 8/11/15, indicated, "He tried to ask other clients for their cigarettes which they would not give him any. He then locked himself in the med room (where the cigarettes are kept) and before staff could get the key to get in, he broke into the drawe (sic) where the cigarettes are kept and broke all of them that where (sic) in there. Staff got him to another area until he calmed down...." There was no documentation the facility investigated the incident. There was no documentation indicating</p>			

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	<p>how client A accessed the medication room to destroy the cigarettes. There was no documentation indicating what the staff implemented to redirect client A. There was no documentation of corrective action.</p> <p>On 9/8/15 at 4:46 PM, the PD indicated she did not conduct the investigation. The PD indicated the day program PD should have conducted an investigation. The PD indicated the medication room should have been closed and locked. The PD stated, "either staff left open or he got the keys." The PD indicated she was not sure how client A was able to access the medication room.</p> <p>On 9/9/15 at 9:43 AM, the AD indicated in an email when the investigation for the incident was requested, "I didn't think this one needed an investigation, it didn't involve other clients and didn't seem with it being here during the day and that most of these type of issues are brought to our attention that there was any questionable issues with staff in this case."</p> <p>On 9/10/15 at 11:10 AM, the DPPD indicated the incident should have been investigated. The DPPD indicated client A was in the room with staff due to it being time for his cigarette. Client A was given his cigarettes but did not want the</p>			

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	<p>kind he was given. The DPPD stated client A "tore the drawer up and took the cigarettes." The DPPD indicated there was no corrective action taken with the staff.</p> <p>On 9/10/15 at 11:10 AM, the PC indicated the incident should have been investigated.</p> <p>On 9/10/15 at 11:10 AM, the PD indicated the incident should have been investigated.</p> <p>On 9/10/15 at 11:10 AM, the QAS indicated the incident should have been investigated.</p> <p>4) On 7/31/15 at 3:15 PM (reported to BDDS on 8/2/15), client A and other clients were having a water fight at the facility-operated day program. Client A poured water on a peer. The peer did not like it and was not participating. The BDDS report indicated, "This made [initials of peer] upset and started fighting with [client A], staff stepped in and separated them and took them to different parts of the building to calm down." The investigation, dated 8/5/15, indicated the facility was conducting an investigation of peer to peer aggression. The interview with DPS #4 indicated, in part, "Staff went outside and found them</p>			

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	<p>both fighting." The interview with DPS #5 indicated, in part, "When I looked out the window, I saw [initials of peer] go after [client A]. I went out and separated them." Client A's peer's interview indicated, in part, "[Client A] came over and acted like he was going to pour water on me. I told him not to and he did anyway so I hit him. I wasn't going to put up with that s---." There was no documentation in the investigation whether or not the facility substantiated client to client abuse of the incident.</p> <p>On 9/8/15 at 1:30 PM, the PD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The PD indicated there was a policy and procedure in place prohibiting abuse of the clients. The PD indicated BDDS reports should be submitted within 24 hours of the incident. On 9/8/15 at 4:46 PM, the PD indicated she thought there was no contact between the two clients. The PD indicated the facility needed to indicate in the investigation whether or not abuse was substantiated. The PD indicated the investigation was not thorough since the facility did not document if client to client abuse was substantiated or not.</p> <p>On 9/8/15 at 12:53 PM, the AD indicated client to client aggression was considered</p>			

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	<p>abuse and the facility should prevent abuse of the clients. The AD indicated there was a policy and procedure in place prohibiting abuse of the clients. The AD indicated BDDS reports should be submitted within 24 hours of the incident.</p> <p>On 9/10/15 at 11:10 AM, the QAS indicated the investigators were told to write what the evidence found. The QAS indicated she was instructed to not write substantiated or unsubstantiated.</p> <p>5) On 7/30/15 at 8:30 PM, the BDDS report, dated 7/31/15, indicated, in part, "Client [A] got on the group home telephone while staff was talking to [client A's] grandma and grandma stated that she didn't want [client A] coming to her house this weekend. [Client A] went downstairs and became destructive and broke downstairs telephone. After taking a swing to punch a housemate, staff put [client A] in an approved PIA (Positive Intervention Assignment) hold for approx (approximately) 3 minutes. Housemate called the cops and another staff who was working talked to police and explained the situation. HM (home manager) came to take initial staff to get his inhaler that he needed after incident. All calmed down and remained calm for remainder of evening." The investigation indicated the facility conducted an investigation</p>			

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	<p>into peer to peer aggression. The Conclusion of the investigation indicated, "Evidence supports staff intervened appropriately." There was no documentation whether or not the facility substantiated client to client abuse. This affected clients B, C, E, F, G and H.</p> <p>On 9/8/15 at 4:46 PM, the PD indicated she thought there was no contact between the two clients. The PD indicated the investigation was not thorough since the facility did not document if client to client abuse was substantiated or not.</p> <p>On 9/10/15 at 11:10 AM, the QAS indicated the investigators were told to write what the evidence found. The QAS indicated she was instructed to not write substantiated or unsubstantiated.</p> <p>6) On 7/28/15 at 3:30 PM at the facility operated day program, client A became agitated and punched the walls. When staff intervened, client A bit himself on the hand and ran over to client H and hit him. Client H hit him back and staff separated the clients. The group home van arrived and as client A walked out he yelled at a peer who was in another van. Client A picked up a rock and threw it through the window of the van the peer was in. Client A ran around staff and opened the door to the van. After the</p>			

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	<p>incident, the peer had a bite mark on his right arm. At 4:15 PM, the police showed up to the day program due to a neighboring business calling the police. Client A was taken to the hospital to have his arm checked due to self-injurious behavior of biting himself.</p> <p>The investigation, dated 8/4/15, indicated the facility was conducting an investigation of peer to peer aggression and property destruction. The Conclusion of the investigation indicated, "Evidence supports staff intervened appropriately." The Recommendations section indicated, "It has been recommended that [client A] see a psychiatrist for his anger issues and follow their recommendations accordingly...." There was no documentation included in the investigation indicating whether or not client A was seen by a psychiatrist. There was no documentation in the investigation indicating whether the facility substantiated client to client abuse.</p> <p>On 9/8/15 at 2:13 PM, the nurse indicated client A did not have a psychiatric evaluation since he was admitted on 4/10/15. The nurse indicated due to client A's history the facility was having a difficult time finding a</p>			

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	<p>psychiatrist to see him. The nurse indicated an appointment was made with a psychiatrist but the appointment was not held due to client A being in the hospital at the time of the appointment. The appointment was rescheduled but not held due to client A being arrested.</p> <p>On 9/8/15 at 1:30 PM, the PD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The PD indicated there was a policy and procedure in place prohibiting abuse of the clients. On 9/8/15 at 4:46 PM, the PD indicated the facility needed to indicate in the investigation whether or not abuse was substantiated. The PD indicated the investigation was not thorough since the facility did not document if client to client abuse was substantiated or not.</p> <p>On 9/8/15 at 12:53 PM, the AD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AD indicated there was a policy and procedure in place prohibiting abuse of the clients. The AD indicated BDDS reports should be submitted within 24 hours of the incident.</p> <p>7) On 7/25/15 at 9:30 PM, client A told staff he wanted to go fishing. Staff explained it was too late to go fishing and</p>			

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	<p>client A became angry. Client A started throwing things and ripped the door off of the medicine cabinet. Client A told staff he took someone's medicine. Staff was instructed to take client A to the emergency room. Client A was admitted to the hospital's locked unit for observation. He was released on 7/26/15. This affected clients B, C, E, F, G and H.</p> <p>The investigation, dated 7/29/15, indicated staff #4 and staff #11 were present during the incident. Staff #4 indicated in the investigation she and staff #11 stayed upstairs during the incident. Staff #4 indicated the staff stayed upstairs to keep the other clients safe and calm. Staff #4 indicated client A came upstairs and told the staff he had taken someone else's medications. Staff #4 indicated she went downstairs and could not determine what medications client A took due to client A destroying several medication pouches. Staff #11 indicated he was upstairs when the incident occurred. Staff #11 indicated when client A came upstairs he indicated he took someone else's medications. Staff #11 went downstairs and could not determine what client A took. The Conclusion of the investigation indicated, "Evidence supports staff did not intervene appropriately and evidence supports staff did not follow protocol(s)." The</p>			

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	<p>Recommendations section indicated, "In order to prevent the likelihood of future occurrence, staff will be retrained on [client A's] behavior plan. Staff will also be retrained on having one staff downstairs if clients are down there so they are not left unattended." There was no documentation the training was conducted. There was no documentation the facility identified the incident as neglect. The staff failed to provide client A supervision in order to maintain his health and safety. The facility failed to take appropriate corrective action with the staff due to failing to supervise client A during the incident.</p> <p>On 9/8/15 at 1:58 PM, the PD indicated client A destroyed medications from the medicine cabinet. The PD indicated the staff was unable to tell what was ingested or destroyed.</p> <p>On 9/8/15 at 1:58 PM, the AD indicated the hospital told the group home client A ingested others' medications.</p> <p>On 9/10/15 at 11:10 AM, the PD indicated the staff was trained on 8/26/15. The PD indicated the training was not conducted timely. The PD indicated the staff was provided information prior to the 8/26/15 training however there was no documentation of the training.</p>			

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	<p>On 9/10/15 at 11:10 AM, the PC indicated the training was not timely. The PC indicated the staff received communication from her to have one staff upstairs and one staff downstairs prior to the 8/26/15 meeting in the communication book. The PC indicated she was not aware the staff did not intervene during the behavior. The PC stated the incident was "neglect." The PC indicated the staff should have received corrective actions.</p> <p>On 9/10/15 at 11:10 AM, the DPPD indicated he was on-call at the time of the incident. The DPPD indicated the staff did not inform him they did not intervene during the incident. The DPPD stated the incident was "neglect."</p> <p>On 9/10/15 at 11:10 AM, the QAS stated the incident was "neglect." The QAS indicated the facility should have implemented corrective actions with the staff.</p> <p>On 9/10/15 at 11:10 AM, the PD stated the incident was "neglect." The PD indicated the facility did not implement corrective actions with the staff. The PD indicated corrective action should have been implemented.</p>			

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	<p>8) On 6/17/15 at 7:00 PM, the BDDS report indicated, "[Client A] became aggitated (sic) after he was confronted by staff, [#8], about stealing cigarettes out of his car. Staff offered to take [client A] to get tubes and tobacco but he started getting verbally aggressive because he wanted to purchase packs of cigarettes. [Client A] went into his bed room and began hitting his walls with a baseball bat. [Client A] left his room and threatned (sic) staff. [Client A] hit housemate [client H] in the face and broke his glasses. [Client A] hit staff with a rock and a rake. Staff got other housemates into the van to keep them safe. [Client A] hit the windshild (sic) of the van and staff's vehicle with rocks and broke them. [Client A] also broke out a couple windows of the GH (group home). Staff contacted the police. [Client A] was admitted to the hospital on a 72 hour hold." This affected clients B, C, E, F, G and H.</p> <p>The 6/22/15 investigation indicated the facility conducted an investigation of peer to peer aggression and property destruction. The investigation indicated in the Conclusion section, "Evidence supports staff did not intervene appropriately and evidence supports staff followed protocol(s)." The Recommendations section indicated, "In</p>			

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	<p>order to prevent the likelihood of future occurrence, the team will meet to discuss making changes to his behavior plan." There was no documentation addressing the staff failed to intervene appropriately. There was no documentation discussing how the staff did not intervene appropriately but followed the protocols. There was no documentation the staff were trained to lock their vehicles and keep their keys secured while working at the group home.</p> <p>On 9/8/15 at 4:14 PM, staff #8 indicated the cigarettes were stolen out of his bag he brought into the house and not his car. Staff #8 indicated he observed his cigarettes in client A's pocket. Staff #8 told client A he stole the cigarettes from him due to the brand of the cigarettes. Staff #8 indicated client A locked himself in his room and tore his room apart. Staff #8 indicated client A hit client H.</p> <p>On 9/8/15 at 4:08 PM, staff #3 indicated client A hit client H multiple times in the face during the incident, breaking client H's glasses. Staff #3 indicated client A broke staff #8's windshield and tried to smash the windshield of the group home van. Staff #3 indicated the other 6 clients were in the van at the time. Staff #3 indicated she called the police when client A obtained a kitchen knife which</p>			

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	<p>was dull. Staff #3 indicated client A cut himself with broken glass. Staff #3 stated, "no one could handle him."</p> <p>On 9/8/15 at 1:30 PM, the PD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The PD indicated there was a policy and procedure in place prohibiting abuse of the clients. On 9/8/15 at 2:00 PM, the PD indicated the staff should have locked his doors. The PD indicated it was discussed to add locking car doors to client A's plan but she was not sure if it was added. On 9/8/15 at 4:46 PM, the PD indicated the facility needed to indicate in the investigation whether or not abuse was substantiated. The PD indicated the investigation was not thorough since the facility did not document if client to client abuse was substantiated or not. The PD indicated the facility should have implemented corrective action following the incident. The PD indicated she did not ask staff how client A entered the staff's car. The PD indicated she should have asked the staff if his doors were locked or not during the interview.</p> <p>On 9/8/15 at 12:53 PM, the AD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The AD indicated</p>			

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	<p>there was a policy and procedure in place prohibiting abuse of the clients. On 9/8/15 at 1:18 PM, the AD indicated the staff should have locked his doors.</p> <p>On 9/8/15 at 1:22 PM, a review of client A's Behavior Support Plan, dated 5/6/15, indicated there was no plan for staff to lock their car doors or secure their car keys while working at the group home.</p> <p>On 9/10/15 at 11:10 AM, the PD indicated staff #8's keys were missing from his bag. The PD indicated the information should have been included in the investigation. The PD indicated her use of the word "confronted" was the wrong word. The PD indicated staff #8 asked client A about stealing his cigarettes and then offered to take client A to get his own. The PD indicated staff #8 did not tell her how client A got his cigarettes. The PD indicated she mainly focused on the property destruction portion since client A destroyed so much stuff during the incident. The PD indicated staff #8 should have not left his car keys where client A could access them. The PD indicated staff locking their vehicles and keeping their keys secured should have been added to client A's plan. The PD indicated the incident could have been avoided if staff #8 did not leave his keys accessible to client A.</p>			

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	<p>The PD indicated following the incident, property destruction was discussed being added to his plan. The PD indicated the date on the plan should have been updated. The PD indicated she checked the wrong box on the investigation. The PD indicated the investigation was not thorough.</p> <p>The facility's policy and procedures related to abuse and neglect were reviewed on 9/8/15 at 1:23 PM. The facility's Quality and Risk Management policy dated April 2011 indicated, "Indiana MENTOR promotes a high quality of service and seeks to protect individuals receiving Indiana MENTOR services through oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed." The policy defined neglect as, "e. Failure to provide appropriate supervision, care or training; f. Failure to provide a safe, clean and sanitary environment; g. Failure to provide food and medical services as needed; h. Failure to provide medical supplies or safety equipment as indicated in the ISP." The Human Rights policy, dated April 2011, indicated, in part, "The following actions are prohibited by employees of Indiana MENTOR: abuse,</p>			

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W 0153 Bldg. 00	<p>neglect, exploitation or mistreatment of an individual including misuse of an individual's funds; or violation of an individual's rights."</p> <p>This federal tag relates to complaint #IN00180377.</p> <p>9-3-2(a)</p> <p>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.</p> <p>Based on record review and interview for 1 of 8 incident reports reviewed affecting client A, the facility failed to submit an incident report to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>On 9/8/15 at 11:56 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 7/31/15 at 3:15 PM (reported to BDDS on 8/2/15), client A and other clients were having a water</p>	W 0153	<p>Program Directors (QIDP) will be retrained on completing BDDS reports in a timely manner and implementing appropriate corrective actions to address the incidents. Area Director will review with Program Directors (QIDP) weekly all incidents to ensure that they are completed timely. Corrective action will be completed as necessary.</p>	10/16/2015

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	<p>fight at the facility-operated day program. Client A poured water on a peer. The peer did not like it and was not participating. The BDDS report indicated, "This made [initials of peer] upset and started fighting with [client A] staff stepped in and separated them and took them to different parts of the building to calm down." The investigation, dated 8/5/15, indicated the facility was conducting an investigation of peer to peer aggression. The interview with DPS #4 indicated, in part, "Staff went outside and found them both fighting." The interview with DPS #5 indicated, in part, "When I looked out the window, I saw [initials of peer] go after [client A]. I went out and separated them." Client A's peer's interview indicated, in part, "[Client A] came over and acted like he was going to pour water on me. I told him not to and he did anyway so I hit him. I wasn't going to put up with that s---."</p> <p>On 9/8/15 at 1:30 PM, the Program Director indicated BDDS reports should be submitted within 24 hours of the incident.</p> <p>On 9/8/15 at 12:53 PM, the Area Director indicated BDDS reports should be submitted within 24 hours of the incident.</p>			

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W 0154 Bldg. 00	<p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 8 of 8 incident/investigative reports reviewed affecting clients A, B, C, E, F, G and H, the facility failed to conduct thorough investigations.</p> <p>Findings include:</p> <p>On 9/8/15 at 11:56 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 8/14/15 at 9:00 AM, the Bureau of Developmental Disabilities Services (BDDS) incident report for the facility-operated day program, dated 8/14/15, indicated, "At 9:00 am [client A] became upset before leaving for an outing because he was not allowed to sit by his girlfriend in the very backseat of the van. He continued to escalate and went to the front office where he pulled a knife out of his pocket and held it to his stomach saying that he was going to kill himself. [Day Program (DP) staff #1]</p>	W 0154	<p>Program Directors (QIDP) will be retrained on Internal Investigation Procedures, including what requires an investigation, who is interviewed, what documents should be reviewed, gathering all pertinent information, listing the specific conclusion for the investigation, determining any corrective action required and completing follow up as needed.</p> <p>Area Director and / or Quality Assurance Specialist will review all investigations upon completion to review for required (retrained) content.</p>	10/16/2015

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	<p>was trying to calm him down when [client A] took the knife and stabbed [DP staff #1] in the upper right shoulder. The police were called and [client A] was handcuffed and taken to jail. [DP staff #1] had 7 sutures inside the wound and 11 sutures to close the wound and the knife nicked the bone. [Client A's] IDT (interdisciplinary team) will be meeting on 8/18/15. Staff will continue to follow policy and procedure (sic) to ensure the health and safety of all clients."</p> <p>The investigation, dated 8/21/15, indicated in Day Program Staff (DPS) #2's interview, in part, "[DPS #2] stated that she told [DPS #3] 'privately' that [client A] and another female client [initials] aren't supposed to sit next to each other in the van. [DPS #2] stated that she heard [DPS #3] tell [client A] that he couldn't sit next to [client A's girlfriend's initials] in the van and he then came 'storming over' to her while she was putting client lunches in the refrigerator and 'picked me up and slammed me into the refrigerator hard.' [DPS #2] stated that she was able to get to a chair and sit down but that [client A] had gone out the door of the day program and into the office door. She stated that she saw him coming back and went toward the hallway and [client A] blocked her and [DPS #3's] way into the med room and so</p>			

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	<p>she went to the music room because she felt he was 'looking at me' and 'targeting me.' [DPS #2] stated that she and [DPS #4] had several clients in the music room with them with the door closed until [client A] went back to the big day program room. She stated that she and [DPS #3] went back into the big day program room and [client A] went outside and began to throw rocks at the windows. [DPS #2] stated that she moved clients away from the windows to the back of the room in case the windows were to break. She stated that she began moving clients to the music room and [DPS #3] and [staff from another provider] told her to get into the room with the clients so that [client A] wouldn't try to hurt her again. [DPS #2] stated that when she came out of the music room again, she saw [DPS #1] outside with [client A] and she saw [client A] with a 'shiny thing pointed at his stomach.' She stated that she and [DPS #5] were in the big room with clients at that time and so she went to the med room to get clients their cigarettes and locked herself in the room (without any clients) and called [name of Day Program Coordinator] (PC for day program who was off work on this day) to report what was happening. [DPS #2] stated that she was in there 'quite some time' and then heard someone say that</p>			

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	<p>[DPS #1] had gotten hurt so she came out of the room... [DPS #2] stated that when she came out of the med room, she found that the police were there and wanted to talk to her...."</p> <p>The Conclusion section of the investigation indicated, "[Client A] had behaviors in the day program that resulted in an injury to staff." The investigation indicated, in part, "Staff interviewed stated that [name of client A's girlfriend] seating arrangement plan to sit in the front seat on outings is a verbal instruction. No written documentation was found to support this plan or to support that all staff have been trained on this plan." The investigation did not indicate whether or not the staff implemented client A's program plan as written. The investigation did not address how client A was in possession of a knife. The investigation did not include an interview or an attempted interview with client A.</p> <p>On 9/8/15 at 2:06 PM, a review of client A's record was conducted. Client A's 5/13/15 Individualized Support Plan (ISP) indicated, in part, "[Client A] has diagnoses of Intermittent Explosive Disorder, Sexual Abuse of a Child, and Oppositional Defiance Disorder. [Client A] displays behaviors such as property</p>			

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	<p>destruction, physical aggression, self-injurious behavior, elopement, and sexual acting out."</p> <p>Client A's Behavior Support Plan, dated 5/6/15, indicated he had the following targeted behaviors: physical aggression, injurious to self/suicidal ideation, absent without notification or permission, resistance to instruction and property destruction. The BSP indicated, "[Client A's] team will secure a psychiatric referral within 30 days...." There was no documentation of a psychiatric referral in client A's record for review. Client A had a counseling appointment on 8/4/15. The BSP had a note, dated 8/18/15, "All sharp objects must be kept in a locked container with staff only having access to the container due to several instances of property destruction using sharp objects, claims of suicidal thoughts and, physical aggression toward others using sharp objects."</p> <p>On 9/8/15 at 12:17 PM, the Area Director (AD) indicated the incident started when client A was told he could not sit in the back of the van with his girlfriend. The AD indicated the incident could have been avoided if the staff at the day program had put client A on the phone with him (client A was asking to speak to the AD) and staff stayed out of arm's</p>			

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	<p>length of client A. The AD indicated there was no plan for client A's girlfriend to sit in the front seat of the van. The AD indicated the staff could have sat in the back of the van with the clients. The AD stated, "the whole thing could have been avoided." The AD indicated the investigation did not address where the knife was obtained. The AD indicated client A told the AD he got the knife from a friend. The AD indicated he thought client A obtained the knife from his uncle. The AD indicated none of the staff, prior to the incident, was aware he had a knife. The AD indicated the stabbing was witnessed by the Program Director and the receptionist. The AD indicated client A had been in jail since the incident and there was no plan of returning client A to the group home or the day program.</p> <p>On 9/8/15 at 4:46 PM, the PD indicated she and the AD spoke to client A following the incident and prior to his arrest. The PD indicated she did not document her interview with client A but should have.</p> <p>On 9/10/15 at 11:10 AM, Quality Assurance Specialist (QAS) indicated DPS #2 told her during the investigation that client A was targeting her. The QAS indicated at one point, DPS #2 was in the</p>			

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	<p>music room with several clients but left the area to get cigarettes for the clients. The DPS #2 indicated client A was targeting her so she locked herself in the medication room and stayed in there for quite a while. The QAS indicated she did not indicate in the investigation whether or not staff implemented client A's plan as written. The QAS indicated she thought the staff implemented the plan as written after reviewing the plan. The QAS indicated the staff offered other activities and used the least restrictive interventions. The QAS indicated the investigation should have addressed whether or not the staff implemented the plan. The QAS indicated although she did not document her attempts to find out how client A obtained the knife, she indicated she contacted the Program Coordinator (PC). The QAS indicated she was unable to figure out where the knife came from. The QAS indicated this information should have been included in the investigation. The QAS indicated following the incident, client A went to jail. The QAS indicated she did not attempt to interview client A for the investigation.</p> <p>2) On 8/11/15 at 8:10 PM, the on-call PD received a call of an incident involving client A. The BDDS incident report indicated, in part, "[Client A] was</p>			

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	<p>upset about a situation involving an outing. [Client A] became physically aggressive and was throwing rocks at staff and then threw a rock at the rear window of the group home van causing the window to break. [Client A's] behavior continued to escalate as staff was attempting to verbally redirect him. [Client A] returned back inside to the group home and went to his room. [Client A] had retrieved a fishing tool from his tackle box and took the tool back outside and damaged the tires of one of the staff's vehicles. Staff contacted the police for assistance due to [client A's] behavior continuing to escalate. After damaging the tires [client A] eloped from the group home. Staff were unable to follow him due to having to stay at the home as there were other residents in the home. Police arrived at the home and staff informed them that [client A] had eloped and that he had a tool, which he had damaged staff's tires with. Police went and looked for [client A] and found him and took him to [name of hospital] for evaluation. [Client A] was released from [name of hospital] at approximately 3 am and on call program coordinator, [name], picked [client A] up from the hospital and he returned to the group home." This affected clients B, C, E, F, G and H.</p>			

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	The investigation, dated 8/17/15, indicated the facility was investigating an incident of elopement, property damage and client A being admitted to the hospital. There was no documentation in the investigation indicating whether or not the facility investigation substantiated or unsubstantiated neglect. The interview with staff #10 in the investigation indicated client A was upset due to not being able to go fishing with client E. Staff #10 indicated staff #11 left the group home with client E and client A wanted to go. Staff #10 indicated client A threw a rock at the van and staff #11 kept driving. Staff #10 stated in the investigation, "he couldn't remember what happened after that. Claimed that he 'blacked out.'" Staff #11's interview in the investigation indicated client E was scheduled to go on a one on one outing and client E wanted to go fishing. Staff #11 indicated client E did not want client A to go fishing with him. Staff #11 observed client A coming toward the van with a rock. Client A hit the van and broke the window with the rock. Staff #11 indicated he left the group home to go to the park to locate the AD for assistance. Staff #3 indicated in the investigation staff #11 was leaving with client E. Client A was upset and went outside. Client A picked up a rock and threw it at the van. Client A went to his			

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	<p>room and got a tool to flatten staff #11's tires. Staff #3 attempted to contact the Home Manager and did not reach her. Staff #3 indicated she called the police when she could not locate client A. The Conclusion of the investigation indicated, "Evidence supports staff did not intervene appropriately." The Recommendations section indicated, "In order to prevent the likelihood of future occurrence, staff will discuss how to effectively manage [client A's] behaviors at the next staff meeting. If [client A] is having a behavior, one staff person is not to leave the other staff alone with him and other clients. They need to assist until the situation has been deescalated."</p> <p>There was no documentation in the investigation the facility did not have sufficient staff at the time of the incident. There was no documentation indicating how long it took the police to locate client A and where he was located.</p> <p>On 9/8/15 at 12:53 PM, the Area Director (AD) indicated client A required 24 hour supervision. The AD stated staff #3 was "negligent." On 9/8/15 at 1:02 PM, the AD indicated there was one staff at the group home at the time client A eloped. The AD indicated the second staff took client E to go fishing. The AD indicated he went to the house after the incident</p>			

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	<p>was over. The AD indicated the clients at the group home were aware of what occurred (throwing rocks, flattening staff's tires) but staff #3 did not know. The AD indicated staff #3 should have kept client A in line of sight. The AD indicated staff #3 contacted him and at the time did not know where client A was located. The AD indicated staff #3 was at the home with client A and 5 additional clients. The AD indicated client A had just returned to the group home from football practice. Client A wanted to go fishing with client E but client E did not want client A to go with him. The AD indicated client E skipped football practice and should not have been taken fishing. The AD stated the staff "rewarded" client E by taking him fishing even though he skipped practice. The AD indicated there was no plan to keep client E home if he skipped practice but if he indicated he could not practice then the staff should not have taken him fishing. The AD indicated client A used a multitool to let the air out of staff's tires and break his window. The AD stated staff #3 was "freaking out" while talking to him on the phone even when client A was outside the group home. The AD indicated the staff needed to stay calm during incidents. The AD indicated staff #11 took client E to the park to look for the AD. The AD stated staff #11 should</p>			

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	<p>have "never left the house" when the situation was going on. The AD indicated staff #11 was driving the group home van when client A threw a rock at the van and broke the window. The AD indicated staff #11 knew there was an incident occurring at the group home when he left. The AD indicated one staff was sufficient to implement the clients' plans.</p> <p>On 9/8/15 at 1:30 PM, the Program Director (PD) indicated client A required 24 hour supervision. The PD stated the incident was "neglect." The PD indicated staff #3 should have kept client A within line of sight. On 9/8/15 at 4:46 PM, the PD indicated the investigation did not indicate how long client A was unsupervised and it should have been included. The PD indicated staff #11 left the group home with client E during the incident to find the Area Director for assistance. The PD indicated staff #11 should not have left the group home during the incident. The PD stated, "there should have been another staff here since there was a planned outing (with client E)." The PD indicated there was insufficient staff at the group home at the time of the incident.</p> <p>On 9/10/15 at 11:10 AM, the PD indicated there was sufficient staff at the</p>			

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	<p>home until staff #11 left the home with client E. The PD indicated the staffing level at the home was 1 staff to 4 clients. The PD indicated the investigation should have indicated there was insufficient staff at the group home when staff #11 left with client E. The PD indicated the investigation should have indicated how long client A was unsupervised. The PD indicated he was unsupervised for 17 minutes.</p> <p>3) On 8/10/15 at 2:00 PM at the facility-operated day program, client A became upset due to not liking the cigarettes the group home sent for him. The BDDS report, dated 8/11/15, indicated, "He tried to ask other clients for their cigarettes which they would not give him any. He then locked himself in the med room (where the cigarettes are kept) and before staff could get the key to get in, he broke into the drawe (sic) where the cigarettes are kept and broke all of them that where (sic) in there. Staff got him to another area until he calmed down...." There was no documentation the facility investigated the incident. There was no documentation indicating how client A accessed the medication room to destroy the cigarettes. There was no documentation indicating what the staff implemented to redirect client A.</p>			

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	<p>On 9/8/15 at 4:46 PM, the PD indicated she did not conduct the investigation. The PD indicated the day program PD should have conducted an investigation. The PD indicated the medication room should have been closed and locked. The PD stated, "either staff left open or he got the keys." The PD indicated she was not sure how client A was able to access the medication room.</p> <p>On 9/9/15 at 9:43 AM, the AD indicated in an email when the investigation for the incident was requested, "I didn't think this one needed an investigation, it didn't involve other clients and didn't seem with it being here during the day and that most of these type of issues are brought to our attention that there was any questionable issues with staff in this case."</p> <p>On 9/10/15 at 11:10 AM, the DPPD indicated the incident should have been investigated. The DPPD indicated client A was in the room with staff due to it being time for his cigarette. Client A was given his cigarettes but did not want the kind he was given. The DPPD stated client A "tore the drawer up and took the cigarettes."</p> <p>On 9/10/15 at 11:10 AM, the PC indicated the incident should have been investigated.</p>						

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	<p>On 9/10/15 at 11:10 AM, the PD indicated the incident should have been investigated.</p> <p>On 9/10/15 at 11:10 AM, the QAS indicated the incident should have been investigated.</p> <p>4) On 7/31/15 at 3:15 PM (reported to BDDS on 8/2/15), client A and other clients were having a water fight at the facility-operated day program. Client A poured water on a peer. The peer did not like it and was not participating. The BDDS report indicated, "This made [initials of peer] upset and started fighting with [client A], staff stepped in and separated them and took them to different parts of the building to calm down." The investigation, dated 8/5/15, indicated the facility was conducting an investigation of peer to peer aggression. The interview with DPS #4 indicated, in part, "Staff went outside and found them both fighting." The interview with DPS #5 indicated, in part, "When I looked out the window, I saw [initials of peer] go after [client A]. I went out and separated them." Client A's peer's interview indicated, in part, "[Client A] came over and acted like he was going to pour water on me. I told him not to and he did anyway so I hit him. I wasn't going to put</p>			

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	<p>up with that s---." There was no documentation in the investigation whether or not the facility substantiated client to client abuse of the incident.</p> <p>On 9/8/15 at 4:46 PM, the PD indicated she thought there was no contact between the two clients. The PD indicated the facility needed to indicate in the investigation whether or not abuse was substantiated. The PD indicated the investigation was not thorough since the facility did not document if client to client abuse was substantiated or not.</p> <p>On 9/10/15 at 11:10 AM, the QAS indicated the investigators were told to write what the evidence found. The QAS indicated she was instructed to not write substantiated or unsubstantiated.</p> <p>5) On 7/30/15 at 8:30 PM, the BDDS report, dated 7/31/15, indicated, in part, "Client [A] got on the group home telephone while staff was talking to [client A's] grandma and grandma stated that she didn't want [client A] coming to her house this weekend. [Client A] went downstairs and became destructive and broke downstairs telephone. After taking a swing to punch a housemate, staff put [client A] in an approved PIA (Positive Intervention Assignment) hold for approx (approximately) 3 minutes. Housemate</p>			

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	<p>called the cops and another staff who was working talked to police and explained the situation. HM (home manager) came to take initial staff to get his inhaler that he needed after incident. All calmed down and remained calm for remainder of evening." The investigation indicated the facility conducted an investigation into peer to peer aggression. The Conclusion of the investigation indicated, "Evidence supports staff intervened appropriately." There was no documentation whether or not the facility substantiated client to client abuse. This affected clients B, C, E, F, G and H.</p> <p>On 9/8/15 at 4:46 PM, the PD indicated she thought there was no contact between the two clients. The PD indicated the investigation was not thorough since the facility did not document if client to client abuse was substantiated or not.</p> <p>On 9/10/15 at 11:10 AM, the QAS indicated the investigators were told to write what the evidence found. The QAS indicated she was instructed to not write substantiated or unsubstantiated.</p> <p>6) On 7/28/15 at 3:30 PM at the facility operated day program, client A became agitated and punched the walls. When staff intervened, client A bit himself on the hand and ran over to client H and hit</p>			

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	<p>him. Client H hit him back and staff separated the clients. The group home van arrived and as client A walked out he yelled at a peer who was in another van. Client A picked up a rock and threw it through the window of the van the peer was in. Client A ran around staff and opened the door to the van. After the incident, the peer had a bite mark on his right arm. At 4:15 PM, the police showed up to the day program due to a neighboring business calling the police. Client A was taken to the hospital to have his arm checked due to self-injurious behavior of biting himself.</p> <p>The investigation, dated 8/4/15, indicated the facility was conducting an investigation of peer to peer aggression and property destruction. The Conclusion of the investigation indicated, "Evidence supports staff intervened appropriately." The Recommendations section indicated, "It has been recommended that [client A] see a psychiatrist for his anger issues and follow their recommendations accordingly...." There was no documentation included in the investigation indicating whether or not client A was seen by a psychiatrist. There was no documentation in the investigation indicating whether the facility substantiated client to client</p>			

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	<p>abuse.</p> <p>On 9/8/15 at 2:13 PM, the nurse indicated client A did not have a psychiatric evaluation since he was admitted on 4/10/15. The nurse indicated due to client A's history the facility was having a difficult time finding a psychiatrist to see him. The nurse indicated an appointment was made with a psychiatrist but the appointment was not held due to client A being in the hospital at the time of the appointment. The appointment was rescheduled but not held due to client A being arrested.</p> <p>On 9/8/15 at 1:30 PM, the PD indicated the investigation was not thorough since the facility did not document if client to client abuse was substantiated or not.</p> <p>7) On 7/25/15 at 9:30 PM, client A told staff he wanted to go fishing. Staff explained it was too late to go fishing and client A became angry. Client A started throwing things and ripped the door off of the medicine cabinet. Client A told staff he took someone's medicine. Staff was instructed to take client A to the emergency room. Client A was admitted to the hospital's locked unit for observation. He was released on 7/26/15. This affected clients B, C, E, F, G and H.</p>			

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	<p>The investigation, dated 7/29/15, indicated staff #4 and staff #11 were present during the incident. Staff #4 indicated in the investigation she and staff #11 stayed upstairs during the incident. Staff #4 indicated the staff stayed upstairs to keep the other clients safe and calm. Staff #4 indicated client A came upstairs and told the staff he had taken someone else's medications. Staff #4 indicated she went downstairs and could not determine what medications client A took due to client A destroying several medication pouches. Staff #11 indicated he was upstairs when the incident occurred. Staff #11 indicated when client A came upstairs he indicated he took someone else's medications. Staff #11 went downstairs and could not determine what client A took. The Conclusion of the investigation indicated, "Evidence supports staff did not intervene appropriately and evidence supports staff did not follow protocol(s)." The Recommendations section indicated, "In order to prevent the likelihood of future occurrence, staff will be retrained on [client A's] behavior plan. Staff will also be retrained on having one staff downstairs if clients are down there so they are not left unattended." There was no documentation the facility identified the incident as neglect. The staff failed to provide client A supervision in order</p>			

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	<p>to maintain his health and safety.</p> <p>On 9/8/15 at 1:58 PM, the PD indicated client A destroyed medications from the medicine cabinet. The PD indicated the staff was unable to tell what was ingested or destroyed.</p> <p>On 9/8/15 at 1:58 PM, the AD indicated the hospital told the group home client A ingested others' medications.</p> <p>On 9/10/15 at 11:10 AM, the PC indicated she was not aware the staff did not intervene during the behavior.</p> <p>On 9/10/15 at 11:10 AM, the DPPD indicated he was on-call at the time of the incident. The DPPD indicated the staff did not inform him they did not intervene during the incident.</p> <p>8) On 6/17/15 at 7:00 PM, the BDDS report indicated, "[Client A] became aggitated (sic) after he was confronted by staff, [#8], about stealing cigarettes out of his car. Staff offered to take [client A] to get tubes and tobacco but he started getting verbally aggressive because he wanted to purchase packs of cigarettes. [Client A] went into his bed room and began hitting his walls with a baseball bat. [Client A] left his room and threatned (sic) staff. [Client A] hit</p>			

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	<p>housemate [client H] in the face and broke his glasses. [Client A] hit staff with a rock and a rake. Staff got other housemates into the van to keep them safe. [Client A] hit the windshield (sic) of the van and staff's vehicle with rocks and broke them. [Client A] also broke out a couple windows of the GH (group home). Staff contacted the police. [Client A] was admitted to the hospital on a 72 hour hold." This affected clients B, C, E, F, G and H.</p> <p>The 6/22/15 investigation indicated the facility conducted an investigation of peer to peer aggression and property destruction. The investigation indicated in the Conclusion section, "Evidence supports staff did not intervene appropriately and evidence supports staff followed protocol(s)." The Recommendations section indicated, "In order to prevent the likelihood of future occurrence, the team will meet to discuss making changes to his behavior plan." There was no documentation addressing the staff failed to intervene appropriately. There was no documentation discussing how the staff did not intervene appropriately but followed the protocols.</p> <p>On 9/8/15 at 4:46 PM, the PD indicated the facility needed to indicate in the investigation whether or not abuse was</p>			

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	<p>substantiated. The PD indicated the investigation was not thorough since the facility did not document if client to client abuse was substantiated or not. The PD indicated she did not ask staff how client A entered the staff's car. The PD indicated she should have asked the staff if his doors were locked or not during the interview.</p> <p>On 9/10/15 at 11:10 AM, the PD indicated staff #8's keys were missing from his bag. The PD indicated the information should have been included in the investigation. The PD indicated her use of the word "confronted" was the wrong word. The PD indicated staff #8 asked client A about stealing his cigarettes and then offered to take client A to get his own. The PD indicated staff #8 did not tell her how client A got his cigarettes. The PD indicated she checked the wrong box on the investigation. The PD indicated the investigation was not thorough.</p> <p>This federal tag relates to complaint #IN00180377.</p> <p>9-3-2(a)</p>				

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W 0157 Bldg. 00	<p>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 6 of 8 incident/investigative reports reviewed affecting clients A, B, C, E, F, G and H, the facility failed to ensure appropriate corrective actions were implemented.</p> <p>Findings include:</p> <p>On 9/8/15 at 11:56 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 8/14/15 at 9:00 AM, the Bureau of Developmental Disabilities Services (BDDS) incident report for the facility-operated day program, dated 8/14/15, indicated, "At 9:00 am [client A] became upset before leaving for an outing because he was not allowed to sit by his girlfriend in the very backseat of the van. He continued to escalate and went to the front office where he pulled a knife out of his pocket and held it to his stomach saying that he was going to kill himself. [Day Program (DP) staff #1] was trying to calm him down when [client A] took the knife and stabbed [DP staff #1] in the upper right shoulder. The</p>	W 0157	<p>Program Directors (QIDP) will be retrained on Internal Investigation Procedures, including what requires an investigation, who is interviewed, what documents should be reviewed, gathering all pertinent information, listing the specific conclusion for the investigation, determining any corrective action required and completing follow up as needed.</p> <p>Area Director and / or Quality Assurance Specialist will review all investigations upon completion to review for required (retrained) content.</p>	10/16/2015
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	<p>police were called and [client A] was handcuffed and taken to jail. [DP staff #1] had 7 sutures inside the wound and 11 sutures to close the wound and the knife nicked the bone. [Client A's] IDT (interdisciplinary team) will be meeting on 8/18/15. Staff will continue to follow policy and procedure (sic) to ensure the health and safety of all clients."</p> <p>The investigation, dated 8/21/15, indicated in Day Program Staff (DPS) #2's interview, in part, "[DPS #2] stated that she told [DPS #3] 'privately' that [client A] and another female client [initials] aren't supposed to sit next to each other in the van. [DPS #2] stated that she heard [DPS #3] tell [client A] that he couldn't sit next to [client A's girlfriend's initials] in the van and he then came 'storming over' to her while she was putting client lunches in the refrigerator and 'picked me up and slammed me into the refrigerator hard.' [DPS #2] stated that she was able to get to a chair and sit down but that [client A] had gone out the door of the day program and into the office door. She stated that she saw him coming back and went toward the hallway and [client A] blocked her and [DPS #3's] way into the med room and so she went to the music room because she felt he was 'looking at me' and 'targeting me.' [DPS #2] stated that she and [DPS</p>			

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	#4] had several clients in the music room with them with the door closed until [client A] went back to the big day program room. She stated that she and [DPS #3] went back into the big day program room and [client A] went outside and began to throw rocks at the windows. [DPS #2] stated that she moved clients away from the windows to the back of the room in case the windows were to break. She stated that she began moving clients to the music room and [DPS #3] and [staff from another provider] told her to get into the room with the clients so that [client A] wouldn't try to hurt her again. [DPS #2] stated that when she came out of the music room again, she saw [DPS #1] outside with [client A] and she saw [client A] with a 'shiny thing pointed at his stomach.' She stated that she and [DPS #5] were in the big room with clients at that time and so she went to the med room to get clients their cigarettes and locked herself in the room (without any clients) and called [name of Day Program Coordinator] (PC for day program who was off work on this day) to report what was happening. [DPS #2] stated that she was in there 'quite some time' and then heard someone say that [DPS #1] had gotten hurt so she came out of the room... [DPS #2] stated that when she came out of the med room, she found			

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	<p>that the police were there and wanted to talk to her...."</p> <p>The Conclusion section of the investigation indicated, "[Client A] had behaviors in the day program that resulted in an injury to staff." The investigation indicated, in part, "Staff interviewed stated that [name of client A's girlfriend] seating arrangement plan to sit in the front seat on outings is a verbal instruction. No written documentation was found to support this plan or to support that all staff have been trained on this plan." There was no documentation in the investigation indicating the corrective actions the facility implemented to address the lack of a written plan or training staff on the plan. There was no documentation the facility took action with DPS #2 who had locked herself, without any clients, in the medication room during part of the incident.</p> <p>On 9/8/15 at 2:06 PM, a review of client A's record was conducted. Client A's 5/13/15 Individualized Support Plan (ISP) indicated, in part, "[Client A] has diagnoses of Intermittent Explosive Disorder, Sexual Abuse of a Child, and Oppositional Defiance Disorder. [Client A] displays behaviors such as property destruction, physical aggression,</p>			

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	<p>self-injurious behavior, elopement, and sexual acting out."</p> <p>Client A's Behavior Support Plan, dated 5/6/15, indicated he had the following targeted behaviors: physical aggression, injurious to self/suicidal ideation, absent without notification or permission, resistance to instruction and property destruction. The BSP indicated, "[Client A's] team will secure a psychiatric referral within 30 days...." There was no documentation of a psychiatric referral in client A's record for review. Client A had a counseling appointment on 8/4/15. The BSP had a note, dated 8/18/15, "All sharp objects must be kept in a locked container with staff only having access to the container due to several instances of property destruction using sharp objects, claims of suicidal thoughts and, physical aggression toward others using sharp objects."</p> <p>On 9/8/15 at 2:13 PM, the nurse indicated client A did not have a psychiatric evaluation since he was admitted on 4/10/15. The nurse indicated due to client A's history the facility was having a difficult time finding a psychiatrist to see him. The nurse indicated an appointment was made with a psychiatrist but the appointment was not held due to client A being in the</p>			

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	<p>hospital at the time of the appointment. The appointment was rescheduled but not held due to client A being arrested.</p> <p>On 9/8/15 at 12:17 PM, the Area Director (AD) indicated the incident started when client A was told he could not sit in the back of the van with his girlfriend. The AD indicated the incident could have been avoided if the staff at the day program had put client A on the phone with him (client A was asking to speak to the AD) and staff stayed out of arm's length of client A. The AD indicated there was no plan for client A's girlfriend to sit in the front seat of the van. The AD indicated the staff could have sat in the back of the van with the clients. The AD stated, "the whole thing could have been avoided."</p> <p>On 9/8/15 at 4:46 PM, the PD indicated following the incident, client A's team met to discuss sharps, keeping staff and clients safe and they added advanced restraint techniques to client A's plan. The PD indicated she was unsure, following the incident, if client A's girlfriend's plan was revised to include a plan for her to only sit in the front of the van. The PD indicated his girlfriend's plan should have been revised to ensure consistency. On 9/10/15 at 11:10 AM, the PD indicated the staff was not</p>			

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	<p>retrained following the incident. The PD indicated staff was trained on workplace violence following the incident however the training was already scheduled and not in response to the incident.</p> <p>On 9/10/15 at 11:10 AM, the Day Program Program Director (DPPD) indicated client A's girlfriend had an unwritten rule for her to sit in the front seat of the van due to inappropriate touching. The DPPD indicated, initially, he had the day program staff's training documentation on client A's plans. The DPPD indicated he was unable to locate the documentation. The DPPD indicated he was not aware DPS #2 locked herself in the medication room during the incident. The DPPD indicated DPS #2 needed to be retrained on what to do and where to go during an incident.</p> <p>On 9/10/15 at 11:10 AM, Quality Assurance Specialist (QAS) indicated DPS #2 told her during the investigation that client A was targeting her. The QAS indicated at one point, DPS #2 was in the music room with several clients but left the area to get cigarettes for the clients. The DPS #2 indicated client A was targeting her so she locked herself in the medication room and stayed in there for quite a while. The QAS indicated the facility should have implemented</p>			

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	<p>corrective action with DPS #2 for locking herself in a room during the incident.</p> <p>2) On 8/11/15 at 8:10 PM, the on-call PD received a call of an incident involving client A. The BDDS incident report indicated, in part, "[Client A] was upset about a situation involving an outing. [Client A] became physically aggressive and was throwing rocks at staff and then threw a rock at the rear window of the group home van causing the window to break. [Client A's] behavior continued to escalate as staff was attempting to verbally redirect him. [Client A] returned back inside to the group home and went to his room. [Client A] had retrieved a fishing tool from his tackle box and took the tool back outside and damaged the tires of one of the staff's vehicles. Staff contacted the police for assistance due to [client A's] behavior continuing to escalate. After damaging the tires [client A] eloped from the group home. Staff were unable to follow him due to having to stay at the home as there were other residents in the home. Police arrived at the home and staff informed them that [client A] had eloped and that he had a tool, which he had damaged staff's tires with. Police went and looked for [client A] and found him and took him to [name of hospital] for evaluation. [Client A]</p>			

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	<p>was released from [name of hospital] at approximately 3 am and on call program coordinator, [name], picked [client A] up from the hospital and he returned to the group home." This affected clients B, C, E, F, G and H.</p> <p>The investigation, dated 8/17/15, indicated the facility was investigating an incident of elopement, property damage and client A being admitted to the hospital. The interview with staff #10 in the investigation indicated client A was upset due to not being able to go fishing with client E. Staff #10 indicated staff #11 left the group home with client E and client A wanted to go. Staff #10 indicated client A threw a rock at the van and staff #11 kept driving. Staff #10 stated in the investigation, "he couldn't remember what happened after that. Claimed that he 'blacked out.'" Staff #11's interview in the investigation indicated client E was scheduled to go on a one on one outing and client E wanted to go fishing. Staff #11 indicated client E did not want client A to go fishing with him. Staff #11 observed client A coming toward the van with a rock. Client A hit the van and broke the window with the rock. Staff #11 indicated he left the group home to go to the park to locate the AD for assistance. Staff #3 indicated in the investigation staff #11 was leaving</p>			

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	<p>with client E. Client A was upset and went outside. Client A picked up a rock and threw it at the van. Client A went to his room and got a tool to flatten staff #11's tires. Staff #3 attempted to contact the Home Manager and did not reach her. Staff #3 indicated she called the police when she could not locate client A. The Conclusion of the investigation indicated, "Evidence supports staff did not intervene appropriately." The Recommendations section indicated, "In order to prevent the likelihood of future occurrence, staff will discuss how to effectively manage [client A's] behaviors at the next staff meeting. If [client A] is having a behavior, one staff person is not to leave the other staff alone with him and other clients. They need to assist until the situation has been deescalated."</p> <p>There was no documentation in the investigation indicating corrective action was implemented with staff #11. There was no documentation of a staff meeting. There was no documentation staff was retrained.</p> <p>On 9/8/15 at 1:02 PM, the Area Director (AD) indicated there was one staff at the group home at the time client A eloped. The AD indicated the second staff took client E to go fishing. The AD indicated he went to the house after the incident</p>			

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	<p>was over. The AD indicated the clients at the group home were aware of what occurred (throwing rocks, flattening staff's tires) but staff #3 did not know. The AD indicated staff #3 should have kept client A in line of sight. The AD indicated staff #3 contacted him and at the time did not know where client A was located. The AD indicated staff #3 was at the home with client A and 5 additional clients. The AD indicated client A had just returned to the group home from football practice. Client A wanted to go fishing with client E but client E did not want client A to go with him. The AD indicated client E skipped football practice and should not have been taken fishing. The AD stated the staff "rewarded" client E by taking him fishing even though he skipped practice. The AD indicated there was no plan to keep client E home if he skipped practice but if he indicated he could not practice then the staff should not have taken him fishing. The AD indicated client A used a multitool to let the air out of staff's tires and break his window. The AD stated staff #3 was "freaking out" while talking to him on the phone even when client A was outside the group home. The AD indicated the staff needed to stay calm during incidents. The AD indicated staff #11 took client E to the park to look for the AD. The AD stated staff #11 should</p>			

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	<p>have "never left the house" when the situation was going on. The AD indicated staff #11 was driving the group home van when client A threw a rock at the van and broke the window. The AD indicated staff #11 knew there was an incident occurring at the group home when he left. The AD indicated one staff was sufficient to implement the clients' plans.</p> <p>On 9/8/15 at 1:30 PM, the Program Director (PD) indicated client A required 24 hour supervision. The PD stated the incident was "neglect." The PD indicated staff #3 should have kept client A within line of sight. On 9/8/15 at 4:46 PM, the PD indicated staff #11 left the group home with client E during the incident to find the Area Director for assistance. The PD indicated staff #11 should not have left the group home during the incident. The PD indicated there was no corrective action taken with staff #11 for leaving the group home during an incident. The PD stated, "In hindsight, I should have completed corrective action." The PD stated, "there should have been another staff here since there was a planned outing (with client E)." The PD indicated there was insufficient staff at the group home at the time of the incident.</p>			

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	<p>On 9/10/15 at 11:10 AM, the PC indicated client A's theft of cigarettes occurred prior to him leaving for football practice. The PC indicated she was unsure how client A entered the staff's vehicle to get the cigarettes. The PC indicated there was no corrective or disciplinary action taken with staff #11 who left during the incident. The PC indicated staff #11 should have received corrective action.</p> <p>On 9/10/15 at 11:10 AM, the PD indicated she was aware client A had stolen cigarettes from a staff's vehicle. The PD indicated the staff was not trained to lock their vehicles. The PD indicated there was no corrective or disciplinary action taken with staff #11 for leaving in the middle of an incident. The PD indicated the facility should have taken corrective action with staff #11. The PD indicated a staff meeting was held on 8/26/15 to discuss the incident. The PD indicated the 8/26/15 staff meeting included retraining the staff. The PD indicated the staff meeting was not held timely. The PD indicated there was sufficient staff at the home until staff #11 left the home with client E. The PD indicated the staffing level at the home was 1 staff to 4 clients. The PD indicated the investigation should have indicated there was insufficient staff at the group</p>			

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	<p>home when staff #11 left with client E. The PD indicated the investigation should have indicated how long client A was unsupervised. The PD indicated he was unsupervised for 17 minutes.</p> <p>3) On 8/10/15 at 2:00 PM at the facility-operated day program, client A became upset due to not liking the cigarettes the group home sent for him. The BDDS report, dated 8/11/15, indicated, "He tried to ask other clients for their cigarettes which they would not give him any. He then locked himself in the med room (where the cigarettes are kept) and before staff could get the key to get in, he broke into the drawe (sic) where the cigarettes are kept and broke all of them that where (sic) in there. Staff got him to another area until he calmed down...." There was no documentation the facility investigated the incident. There was no documentation indicating how client A accessed the medication room to destroy the cigarettes. There was no documentation indicating what the staff implemented to redirect client A. There was no documentation of corrective action.</p> <p>On 9/10/15 at 11:10 AM, the DPPD indicated there was no corrective action taken with the staff. The DPPD indicated corrective action with the staff should</p>			

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	<p>have been implemented.</p> <p>4) On 7/28/15 at 3:30 PM at the facility operated day program, client A became agitated and punched the walls. When staff intervened, client A bit himself on the hand and ran over to client H and hit him. Client H hit him back and staff separated the clients. The group home van arrived and as client A walked out he yelled at a peer who was in another van. Client A picked up a rock and threw it through the window of the van the peer was in. Client A ran around staff and opened the door to the van. After the incident, the peer had a bite mark on his right arm. At 4:15 PM, the police showed up to the day program due to a neighboring business calling the police. Client A was taken to the hospital to have his arm checked due to self-injurious behavior of biting himself.</p> <p>The investigation, dated 8/4/15, indicated the facility was conducting an investigation of peer to peer aggression and property destruction. The Conclusion of the investigation indicated, "Evidence supports staff intervened appropriately." The Recommendations section indicated, "It has been recommended that [client A] see a psychiatrist for his anger issues and follow their recommendations</p>			

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	<p>accordingly...." There was no documentation included in the investigation indicating whether or not client A was seen by a psychiatrist.</p> <p>On 9/8/15 at 2:13 PM, the nurse indicated client A did not have a psychiatric evaluation since he was admitted on 4/10/15. The nurse indicated due to client A's history the facility was having a difficult time finding a psychiatrist to see him. The nurse indicated an appointment was made with a psychiatrist but the appointment was not held due to client A being in the hospital at the time of the appointment. The appointment was rescheduled but not held due to client A being arrested.</p> <p>5) On 7/25/15 at 9:30 PM, client A told staff he wanted to go fishing. Staff explained it was too late to go fishing and client A became angry. Client A started throwing things and ripped the door off of the medicine cabinet. Client A told staff he took someone's medicine. Staff was instructed to take client A to the emergency room. Client A was admitted to the hospital's locked unit for observation. He was released on 7/26/15. This affected clients B, C, E, F, G and H.</p> <p>The investigation, dated 7/29/15, indicated staff #4 and staff #11 were</p>			

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	<p>present during the incident. Staff #4 indicated in the investigation she and staff #11 stayed upstairs during the incident. Staff #4 indicated the staff stayed upstairs to keep the other clients safe and calm. Staff #4 indicated client A came upstairs and told the staff he had taken someone else's medications. Staff #4 indicated she went downstairs and could not determine what medications client A took due to client A destroying several medication pouches. Staff #11 indicated he was upstairs when the incident occurred. Staff #11 indicated when client A came upstairs he indicated he took someone else's medications. Staff #11 went downstairs and could not determine what client A took. The Conclusion of the investigation indicated, "Evidence supports staff did not intervene appropriately and evidence supports staff did not follow protocol(s)." The Recommendations section indicated, "In order to prevent the likelihood of future occurrence, staff will be retrained on [client A's] behavior plan. Staff will also be retrained on having one staff downstairs if clients are down there so they are not left unattended." There was no documentation the training was conducted. The facility failed to take appropriate corrective action with the staff due to failing to supervise client A during the incident.</p>			

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	<p>On 9/8/15 at 1:58 PM, the PD indicated client A destroyed medications from the medicine cabinet. The PD indicated the staff was unable to tell what was ingested or destroyed. On 9/10/15 at 11:10 AM, the PD indicated the staff was trained on 8/26/15. The PD indicated the training was not conducted timely. The PD indicated the staff was provided information prior to the 8/26/15 training however there was no documentation of the training. The PD stated the incident was "neglect." The PD indicated the facility did not implement corrective actions with the staff. The PD indicated corrective action should have been implemented.</p> <p>On 9/10/15 at 11:10 AM, the PC indicated the training was not timely. The PC indicated the staff received communication from her to have one staff upstairs and one staff downstairs prior to the 8/26/15 meeting in the communication book. The PC indicated she was not aware the staff did not intervene during the behavior. The PC stated the incident was "neglect." The PC indicated the staff should have received corrective actions.</p> <p>On 9/10/15 at 11:10 AM, the DPPD indicated he was on-call at the time of the</p>			

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	<p>incident. The DPPD indicated the staff did not inform him they did not intervene during the incident.</p> <p>On 9/10/15 at 11:10 AM, the QAS stated the incident was "neglect." The QAS indicated the facility should have implemented corrective actions with the staff.</p> <p>6) On 6/17/15 at 7:00 PM, the BDDS report indicated, "[Client A] became aggitated (sic) after he was confronted by staff, [#8], about stealing cigarettes out of his car. Staff offered to take [client A] to get tubes and tobacco but he started getting verbally aggressive because he wanted to purchase packs of cigarettes. [Client A] went into his bed room and began hitting his walls with a baseball bat. [Client A] left his room and threatned (sic) staff. [Client A] hit housemate [client H] in the face and broke his glasses. [Client A] hit staff with a rock and a rake. Staff got other housemates into the van to keep them safe. [Client A] hit the windshild (sic) of the van and staff's vehicle with rocks and broke them. [Client A] also broke out a couple windows of the GH (group home). Staff contacted the police. [Client A] was admitted to the hospital on a 72 hour hold." This affected clients B, C, E, F, G and H.</p>			

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	<p>The 6/22/15 investigation indicated the facility conducted an investigation of peer to peer aggression and property destruction. The investigation indicated in the Conclusion section, "Evidence supports staff did not intervene appropriately and evidence supports staff followed protocol(s)." The Recommendations section indicated, "In order to prevent the likelihood of future occurrence, the team will meet to discuss making changes to his behavior plan." There was no documentation addressing the staff failed to intervene appropriately. There was no documentation discussing how the staff did not intervene appropriately but followed the protocols. There was no documentation the staff were trained to lock their vehicles and keep their keys secured while working at the group home.</p> <p>On 9/8/15 at 4:46 PM, the PD indicated the facility should have implemented corrective action following the incident.</p> <p>On 9/8/15 at 1:22 PM, a review of client A's Behavior Support Plan, dated 5/6/15, indicated there was no plan for staff to lock their car doors or secure their car keys while working at the group home.</p> <p>On 9/10/15 at 11:10 AM, the PD</p>			

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W 0186 Bldg. 00	<p>indicated staff #8 should have not left his car keys where client A could access them. The PD indicated staff locking their vehicles and keeping their keys secured should have been added to client A's plan. The PD indicated the incident could have been avoided if staff #8 did not leave his keys accessible to client A. The PD indicated following the incident, property destruction was discussed being added to his plan. The PD indicated the date on the plan should have been updated.</p> <p>This federal tag relates to complaint #IN00180377.</p> <p>9-3-2(a)</p> <p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on record review and interview for 7 of 7 clients living at the group home at the time of the incident (A, B, C, E, F, G</p>	W 0186	Program Coordinators (formerly Home Managers) will be trained to send weekly schedules to Program	10/16/2015

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	<p>and H), the facility failed to provide sufficient direct care staff to manage and supervise the clients in accordance with their individual program plans.</p> <p>Findings include:</p> <p>On 9/8/15 at 11:56 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 8/11/15 at 8:10 PM, the on-call PD received a call of an incident involving client A. The BDDS incident report indicated, in part, "[Client A] was upset about a situation involving an outing. [Client A] became physically aggressive and was throwing rocks at staff and then threw a rock at the rear window of the group home van causing the window to break. [Client A's] behavior continued to escalate as staff was attempting to verbally redirect him. [Client A] returned back inside to the group home and went to his room. [Client A] had retrieved a fishing tool from his tackle box and took the tool back outside and damaged the tires of one of the staff's vehicles. Staff contacted the police for assistance due to [client A's] behavior continuing to escalate. After damaging the tires [client A] eloped from the group home. Staff were unable to follow him due to having to stay at the home as there were other</p>		<p>Directors (QIDP) for review prior to the work week to ensure appropriate staffing ratios are scheduled for the homes. Training with direct support staff will be completed to review appropriate staffing ratios and their responsibility for changing home activities as needed to ensure appropriate staffing ratios are maintained. Observations will be completed by supervisory staff at least three times per week (one of these being during weekend hours) for four weeks and then at least two times per week ongoing, to monitor that staffing ratios are appropriate to meet clients' needs.</p>	

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	<p>residents in the home. Police arrived at the home and staff informed then that [client A] had eloped and that he had a tool, which he had damaged staff's tires with. Police went and looked for [client A] and found him and took him to [name of hospital] for evaluation. [Client A] was released from [name of hospital] at approximately 3 am and on call program coordinator, [name], picked [client A] up from the hospital and he returned to the group home." This affected clients B, C, E, F, G and H.</p> <p>The investigation, dated 8/17/15, indicated the facility was investigating an incident of elopement, property damage and client A being admitted to the hospital. The interview with staff #10 in the investigation indicated client A was upset due to not being able to go fishing with client E. Staff #10 indicated staff #11 left the group home with client E and client A wanted to go. Staff #10 indicated client A threw a rock at the van and staff #11 kept driving. Staff #10 stated in the investigation, "he couldn't remember what happened after that. Claimed that he 'blacked out.'" Staff #11's interview in the investigation indicated client E was scheduled to go on a one on one outing and client E wanted to go fishing. Staff #11 indicated client E did not want client A to go fishing with</p>			

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	<p>him. Staff #11 observed client A coming toward the van with a rock. Client A hit the van and broke the window with the rock. Staff #11 indicated he left the group home to go to the park to locate the AD for assistance. Staff #3 indicated in the investigation staff #11 was leaving with client E. Client A was upset and went outside. Client A picked up a rock and threw it at the van. Client A went to his room, got a tool to flatten staff #11's tires. Staff #3 attempted to contact the Home Manager and did not reach her. Staff #3 indicated she called the police when she could not locate client A. The Conclusion of the investigation indicated, "Evidence supports staff did not intervene appropriately." The Recommendations section indicated, "In order to prevent the likelihood of future occurrence, staff will discuss how to effectively manage [client A's] behaviors at the next staff meeting. If [client A] is having a behavior, one staff person is not to leave the other staff alone with him and other clients. They need to assist until the situation has been deescalated."</p> <p>On 9/8/15 at 2:06 PM, a review of client A's record was conducted. Client A's 5/13/15 Individualized Support Plan (ISP) indicated, in part, "[Client A] has diagnoses of Intermittent Explosive Disorder, Sexual Abuse of a Child, and</p>			

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	<p>Oppositional Defiance Disorder. [Client A] displays behaviors such as property destruction, physical aggression, self-injurious behavior, elopement, and sexual acting out." The ISP indicated, "Assessment of his/her supervision needs: Requires 24 hour supervision."</p> <p>On 9/8/15 at 4:08 PM, staff #3 indicated she took client A to his football practice and when client A returned to the group home, he took staff #6's keys to her vehicle and stole her cigarettes. Client A then wanted to go with client E on his outing. Client E told client A he wanted to go by himself. Client A got mad and went outside. Staff #3 indicated she asked staff #11 to stay at the group home and not leave with client E. Staff #3 indicated client A ran toward her and she ran around the van several times to stay away from client A as staff #11 and client E were in the van. Staff #3 indicated staff #11 told her to get in the van. Staff #3 indicated she ran to the front of the van and was looking underneath the van to see where client A was located. Staff #3 stated client A "bashed in" the window with a grill brush. Staff #3 indicated staff #11 asked her to move so he could leave in the van. Staff #3 indicated she got client G and assisted him into the group home as client A chased them. Staff #3 indicated she</p>			

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	<p>called the Area Director. Staff #3 indicated she got the other clients out of the house. Staff #3 indicated she did not know where client A was at the time. Staff #3 indicated client A used a tool to stab staff #11's tires and broke out his windows. Staff #3 indicated she called the police. Staff #3 indicated when she turned around client A was gone. Staff #3 indicated she did not know where he was located or how long it took to locate him.</p> <p>On 9/8/15 at 12:53 PM, the Area Director (AD) indicated client A required 24 hour supervision. The AD stated staff #3 was "negligent." On 9/8/15 at 1:02 PM, the AD indicated there was one staff at the group home at the time client A eloped. The AD indicated the second staff took client E to go fishing. The AD indicated he went to the house after the incident was over. The AD indicated the clients at the group home were aware of what occurred (throwing rocks, flattening staff's tires) but staff #3 did not know. The AD indicated staff #3 should have kept client A in line of sight. The AD indicated staff #3 contacted him and at the time did not know where client A was located. The AD indicated staff #3 was at the home with client A and 5 additional clients. The AD indicated staff #11 took client E to the park to look</p>			

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	<p>for the AD. The AD stated staff #11 should have "never left the house" when the situation was going on. The AD indicated staff #11 was driving the group home van when client A threw a rock at the van and broke the window. The AD indicated staff #11 knew there was an incident occurring at the group home when he left. The AD indicated one staff was sufficient to implement the clients' plans.</p> <p>On 9/8/15 at 1:30 PM, the Program Director (PD) indicated client A required 24 hour supervision. The PD stated the incident was "neglect." The PD indicated staff #3 should have kept client A within line of sight. On 9/8/15 at 4:46 PM, the PD indicated staff #11 left the group home with client E during the incident to find the Area Director for assistance. The PD indicated staff #11 should not have left the group home during the incident. The PD stated, "there should have been another staff here since there was a planned outing (with client E)." The PD indicated there was insufficient staff at the group home at the time of the incident. On 9/10/15 at 11:10 AM, the PD indicated there was sufficient staff at the home until staff #11 left the home with client E. The PD indicated the staffing level at the home was 1 staff to 4 clients.</p>			

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W 0189 Bldg. 00	<p>This federal tag relates to complaint #IN00180377.</p> <p>9-3-3(a)</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview for 7 of 7 clients living at the group home at the time of the incident (A, B, C, E, F, G and H), the facility failed to ensure the facility-operated day program staff was trained prior to the incident and trained following a stabbing incident at the facility-operated day program.</p> <p>Findings include:</p> <p>On 9/8/15 at 11:56 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 8/14/15 at 9:00 AM, the Bureau of Developmental Disabilities Services (BDDS) incident report for the</p>	W 0189	<p>Supervisory staff will be trained on completing client specific training for all new clients prior to their start in the group home and / or day program. This training will also consist of completing documented training with staff on any updates to client plans as they occur.</p> <p>Program Directors (QIDP) will review and approve that training is completed prior to direct support staff working a scheduled shift.</p> <p>Supervisory staff will be retrained on completing any necessary training with direct support staff following incidents of client aggression, client injury or other incidents where a review is needed or changes to a client's plan is made. This training</p>	10/16/2015

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	<p>facility-operated day program, dated 8/14/15, indicated, "At 9:00 am [client A] became upset before leaving for an outing because he was not allowed to sit by his girlfriend in the very backseat of the van. He continued to escalate and went to the front office where he pulled a knife out of his pocket and held it to his stomach saying that he was going to kill himself. [Day Program (DP) staff #1] was trying to calm him down when [client A] took the knife and stabbed [DP staff #1] in the upper right shoulder. The police were called and [client A] was handcuffed and taken to jail. [DP staff #1] had 7 sutures inside the wound and 11 sutures to close the wound and the knife nicked the bone. [Client A's] IDT (interdisciplinary team) will be meeting on 8/18/15. Staff will continue to follow policy and procedure (sic) to ensure the health and safety of all clients."</p> <p>The investigation, dated 8/21/15, indicated in Day Program Staff (DPS) #2's interview, in part, "[DPS #2] stated that she told [DPS #3] 'privately' that [client A] and another female client [initials] aren't supposed to sit next to each other in the van. [DPS #2] stated that she heard [DPS #3] tell [client A] that he couldn't sit next to [client A's girlfriend's initials] in the van and he then came 'storming over' to her while she was</p>		<p>with direct support staff will be completed in a timely manner following the incident. Area Director will review with Program Directors (QIDP) weekly all incidents and any recommendations from incidents and / or investigations and ensure that training for direct support staff is completed as needed.</p>	

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	<p>putting client lunches in the refrigerator and 'picked me up and slammed me into the refrigerator hard.' [DPS #2] stated that she was able to get to a chair and sit down but that [client A] had gone out the door of the day program and into the office door. She stated that she saw him coming back and went toward the hallway and [client A] blocked her and [DPS #3's] way into the med room and so she went to the music room because she felt he was 'looking at me' and 'targeting me.' [DPS #2] stated that she and [DPS #4] had several clients in the music room with them with the door closed until [client A] went back to the big day program room. She stated that she and [DPS #3] went back into the big day program room and [client A] went outside and began to throw rocks at the windows. [DPS #2] stated that she moved clients away from the windows to the back of the room in case the windows were to break. She stated that she began moving clients to the music room and [DPS #3] and [staff from another provider] told her to get into the room with the clients so that [client A] wouldn't try to hurt her again. [DPS #2] stated that when she came out of the music room again, she saw [DPS #1] outside with [client A] and she saw [client A] with a 'shiny thing pointed at his stomach.' She stated that she and</p>			

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	<p>[DPS #5] were in the big room with clients at that time and so she went to the med room to get clients their cigarettes and locked herself in the room (without any clients) and called [name of Day Program Coordinator] (PC for day program who was off work on this day) to report what was happening. [DPS #2] stated that she was in there 'quite some time' and then heard someone say that [DPS #1] had gotten hurt so she came out of the room... [DPS #2] stated that when she came out of the med room, she found that the police were there and wanted to talk to her...."</p> <p>The Conclusion section of the investigation indicated, "[Client A] had behaviors in the day program that resulted in an injury to staff." The investigation indicated, in part, "Staff interviewed stated that [name of client A's girlfriend] seating arrangement plan to sit in the front seat on outings is a verbal instruction. No written documentation was found to support this plan or to support that all staff have been trained on this plan." There was no documentation in the investigation indicating the corrective actions the facility implemented to address the lack of a written plan or training staff on the plan. There was no documentation the facility took action with DPS #2 who had</p>			

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	<p>locked herself, without any clients, in the medication room during part of the incident. There was no documentation the facility retrained to the day program staff.</p> <p>On 9/8/15 at 4:46 PM, the PD indicated following the incident, client A's team met to discuss sharps, keeping staff and clients safe and they added advanced restraint techniques to client A's plan. The PD indicated she was unsure, following the incident, if client A's girlfriend's plan was revised to include a plan for her to only sit in the front of the van. The PD indicated his girlfriend's plan should have been revised to ensure consistency. On 9/10/15 at 11:10 AM, the PD indicated the staff was not retrained following the incident. The PD indicated staff was trained on workplace violence following the incident however the training was already scheduled and not in response to the incident.</p> <p>On 9/10/15 at 11:10 AM, the Day Program Program Director (DPPD) indicated client A's girlfriend had an unwritten rule for her to sit in the front seat of the van due to inappropriate touching. The DPPD indicated, initially, he had the day program staff's training documentation on client A's plans. The DPPD indicated he was unable to locate</p>			

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	the documentation. The DPPD indicated DPS #2 needed to be retrained on what to do and where to go during an incident. 9-3-3(a)				