

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G431	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/23/2015
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W 0000  Bldg. 00	<p>This visit was for the investigation of complaint #IN00175974.</p> <p>Complaint #IN00175974: Substantiated, Federal/state deficiencies related to the allegations are cited at W102, W104, W122, W149, W157, W186, W249 and W407.</p> <p>Dates of survey: June 19, 22 and 23, 2015.</p> <p>Facility Number: 000945 Provider Number: 15G431 AIM Number: 100235210</p> <p>The following federal deficiencies reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0102  Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Governing Body for 1 of 3 sampled clients (client A). The Governing Body failed to</p>	W 0102	<p><b>W102: The facility must ensure that specific governing body and management requirements are met.</b></p>	07/23/2015

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>implement written policy and procedures to prevent neglect of client A in regards to client A leaving the group home after a pattern of elopement had been established. The facility's Governing Body failed to ensure behavior protocols were implemented, sufficient staff was provided and corrective measures were taken to prevent elopement of client A.</p> <p>Findings include:</p> <p>Based on observation, record review and interview for 3 of 10 reportable incident reports reviewed, the facility's Governing Body failed for 1 of 3 sampled clients (A), to implement policy and procedures which prohibited neglect of clients and failed to ensure the client's behavioral supervisions needs were met. The facility's Governing Body also neglected to take corrective action to prevent repeated elopement by client A and failed to provide sufficient staff to supervise client A according to her behavioral needs. The Governing Body failed to ensure the facility implemented behavioral protocols according to client A's Behavior Support Plan. Please see W104.</p> <p>Based on observation, record review and interview for 3 of 10 reportable incident reports reviewed, the Governing Body</p>		<p><b>Corrective Action: (specific):</b> Client A is no longer in the home. The Residential Manager will be in-serviced on ensuring proper staffing levels are followed according to the schedule and client behavior support plans and needs. The Direct Care staff will be in-serviced on all client behavior support plans</p> <p><b>How others will be identified: (Systemic):</b> All client behavior plans will be reviewed to ensure that supports are in place as indicated. The Residential Manager will visit the home at least five times weekly to ensure that adequate staffing levels are in place in the home and that all staff is following all client behavior support plans as written. The QIP will visit the home at least weekly to ensure that adequate staffing levels are in place in the home and that all staff is following all client behavior support plans as written.</p> <p><b>Measures to be put in place:</b> Client A is no longer in the home. The Residential Manager will be in-serviced on ensuring proper staffing levels are followed according to the schedule and client behavior support plans and needs. The Direct Care staff will</p>	

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W 0104 Bldg. 00	<p>failed to ensure the Condition of Participation: Client Protections was met for 1 of 3 sampled clients (A). The Governing Body neglected to implement policy and procedure which prohibited neglect of clients by failing to ensure client A did not elope from the facility after a pattern of elopement was established. The Governing Body failed to implement effective corrective measures to ensure client A did not elope from the facility after a pattern of elopement was established. Please see W122.</p> <p>This federal tag relates to complaint #IN00175974.</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 observation, record review and interview for 3 of 10 reportable incident reports reviewed, the facility's Governing Body failed for 1 of 3 sampled clients (A), to implement policy and procedures which prohibited neglect of clients and failed to ensure the client's behavioral</p>	W 0104	<p><b>be in-serviced on all client behavior support plans</b></p> <p><b>Monitoring of Corrective Action:</b> All client behavior plans will be reviewed to ensure that supports are in place as indicated. The Residential Manager will visit the home at least five times weekly to ensure that adequate staffing levels are in place in the home and that all staff is following all client behavior support plans as written. The QIP will visit the home at least weekly to ensure that adequate staffing levels are in place in the home and that all staff is following all client behavior support plans as written.</p> <p><b>Completion date: 7.23.15</b></p> <p><b>W104:</b> The governing body must exercise general policy, budget, and operation discretion over the facility.</p>	07/23/2015

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	<p>supervisions needs were met. The facility's Governing Body also neglected to take corrective action to prevent repeated elopement by client A and failed to provide sufficient staff to supervise client A according to her behavioral needs. The Governing Body failed to ensure the facility implemented behavioral protocols accord to client A's Behavior Support Plan.</p> <p>Findings include:</p> <p>Based on observation, record review and interview for 3 of 10 reportable incident reports reviewed, the Governing Body neglected for 1 of 3 sampled clients (A), to implement policy and procedure which prohibited neglect of clients by failing to ensure client A did not elope from the facility after a pattern of elopement was established. Please see W149.</p> <p>Based on observation, record review and interview for 3 of 10 reportable incident reports reviewed, the Governing Body failed for 1 of 3 sampled clients (A), to implement effective corrective measures to ensure client A did not elope from the facility after a pattern of elopement was established. Please refer to W157.</p> <p>Based on record review and interview for 1 of 10 reportable incident reports</p>		<p><b>Corrective Action: (specific):</b> Client A is no longer in the home. The Residential Manager will be in-serviced on ensuring proper staffing levels are followed according to the schedule and client behavior support plans and needs. The Direct Care staff will be in-serviced on all client behavior support plans</p> <p><b>How others will be identified: (Systemic):</b> All client behavior plans will be reviewed to ensure that supports are in place as indicated. The Residential Manager will visit the home at least five times weekly to ensure that adequate staffing levels are in place in the home and that all staff is following all client behavior support plans as written. The QIP will visit the home at least weekly to ensure that adequate staffing levels are in place in the home and that all staff is following all client behavior support plans as written.</p> <p><b>Measures to be put in place:</b> Client A is no longer in the home. The Residential Manager will be in-serviced on ensuring proper staffing levels are followed according to the schedule and client behavior support plans and needs. The Direct Care staff will</p>	

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W 0122	<p>reviewed, the Governing Body failed for 1 of 3 sampled clients (A), to ensure sufficient staff were available to implement client A's behavior management protocol and prevent her from eloping after a pattern of elopement was established. Please see W186.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (A), the Governing Body failed to ensure implementation of the client's Behavior Management Protocols to prevent elopement from the facility after a pattern of elopement was established. Please see W249.</p> <p>This federal tag relates to complaint #IN00175974.</p> <p>9-3-1(a)</p>	483.420	<p><b>be in-serviced on all client behavior support plans</b></p> <p><b>Monitoring of Corrective Action:</b> All client behavior plans will be reviewed to ensure that supports are in place as indicated. The Residential Manager will visit the home at least five times weekly to ensure that adequate staffing levels are in place in the home and that all staff is following all client behavior support plans as written. The QIP will visit the home at least weekly to ensure that adequate staffing levels are in place in the home and that all staff is following all client behavior support plans as written.</p> <p><b>Completion date: 7.23.15</b></p>		

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Bldg. 00	<p><b>CLIENT PROTECTIONS</b></p> <p>The facility must ensure that specific client protections requirements are met. Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 1 of 3 sampled clients (client A). The facility failed to implement written policy and procedures to prevent neglect of client A in regards to client A leaving the group home after a pattern of elopement had been established.</p> <p>Findings include:</p> <p>Based on observation, record review and interview for 3 of 10 reportable incident reports reviewed, the facility neglected for 1 of 3 sampled clients (A), to implement policy and procedure which prohibited neglect of clients by failing to ensure client A did not elope from the facility after a pattern of elopement was established. Please see W149.</p> <p>Based on observation, record review and interview for 3 of 10 reportable incident reports reviewed, the facility failed for 1 of 3 sampled clients (A), to implement effective corrective measures to ensure client A did not elope from the facility after a pattern of elopement was established. please refer to W157.</p>	W 0122	<p><b>W122: The facility must ensure that specific client protections requirements are met.</b></p> <p><b>Corrective Action: (specific):</b> <b>Client A is no longer in the home. The Residential Manager will be in-serviced on ensuring proper staffing levels are followed according to the schedule and client behavior support plans and needs. The Direct Care staff will be in-serviced on all client behavior support plans</b></p> <p><b>How others will be identified: (Systemic):</b> All client behavior plans will be reviewed to ensure that supports are in place as indicated. The Residential Manager will visit the home at least five times weekly to ensure that adequate staffing levels are in place in the home and that all staff is following all client behavior support plans as written. The QIP will visit the home at least weekly to ensure that adequate staffing levels are in place in the home and that all staff is following all client behavior support plans as written.</p>	07/23/2015

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	This federal tag relates to complaint #IN00175974.  9-3-2(a)		<p><b>Measures to be put in place:</b>  <b>Client A is no longer in the home. The Residential Manager will be in-serviced on ensuring proper staffing levels are followed according to the schedule and client behavior support plans and needs. The Direct Care staff will be in-serviced on all client behavior support plans</b></p> <p><b>Monitoring of Corrective Action:</b>  All client behavior plans will be reviewed to ensure that supports are in place as indicated. The Residential Manager will visit the home at least five times weekly to ensure that adequate staffing levels are in place in the home and that all staff is following all client behavior support plans as written. The QIP will visit the home at least weekly to ensure that adequate staffing levels are in place in the home and that all staff is following all client behavior support plans as written.</p> <p><b>Completion date: 7.23.15</b></p>		

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W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 3 of 10 reportable incident reports reviewed, the facility failed for 1 of 3 sampled clients (A), to implement policy and procedures which prohibited neglect of clients and failed to ensure the client's behavioral supervisions needs were met. The facility also neglected to take corrective action to prevent repeated elopement by client A.</p> <p>Findings include:</p> <p>Observations were conducted at the facility on 6/19/15 from 2:25 PM until 6:10 PM. Client A was absent from the facility. There was no alarm on client A's bedroom window. Residential Manager #1 indicated (6/19/15 at 3:00 PM) client A could disengage an alarm if one was attached on the window so she had client</p>	W 0149	<p><b>W149: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</b></p> <p><b>Corrective Action: (specific):</b> Client A is no longer in the home. The Residential Manager will be in-serviced on ensuring proper staffing levels are followed according to the schedule and client behavior support plans and needs. The Direct Care staff will be in-serviced on all client behavior support plans</p> <p><b>How others will be identified: (Systemic):</b> All client behavior plans will be reviewed to ensure that supports are in place as indicated.</p>	07/23/2015

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	<p>A move her desk in front of the window.</p> <p>Review of reportable incidents, BDDS reports (Bureau of Developmental Disabilities Services) and investigations on 6/19/15 at 4:45 PM and on 6/22/15 at 12:00 PM and 3:08 PM indicated the following:</p> <p>1. A BDDS report dated 5/28/15 indicated client A had eloped from her parents' care (guardians) while visiting her mother in the hospital on 5/27/15 at 7:00 AM. The report indicated client A's father had called the facility to arrange her going back to the group home on the afternoon of 5/27/15 from a leave of absence. Client A "had run away with a guy" instead. The police were contacted and commenced a search.</p> <p>2. A BDDS report dated 6/8/15 indicated client A was found by the police on 6/7/15 at 6:00 PM. Client A "had eloped from her parents (sic) care and was living with an unidentified male...." The report indicated the police removed her from the situation. The client's parents packed up her belongings and returned her to the group home. "[Client A] was visibly upset, screaming profanities at staff and family, and making more threats to leave." The "Plan to Resolve" component of the</p>		<p>The Residential Manager will visit the home at least five times weekly to ensure that adequate staffing levels are in place in the home and that all staff is following all client behavior support plans as written. The QIP will visit the home at least weekly to ensure that adequate staffing levels are in place in the home and that all staff is following all client behavior support plans as written.</p> <p><b>Measures to be put in place:</b> <b>Client A is no longer in the home. The Residential Manager will be in-serviced on ensuring proper staffing levels are followed according to the schedule and client behavior support plans and needs. The Direct Care staff will be in-serviced on all client behavior support plans</b></p> <p><b>Monitoring of Corrective Action:</b> All client behavior plans will be reviewed to ensure that supports are in place as indicated. The Residential Manager will visit the home at least five times weekly to ensure that adequate staffing levels are in place in the home and that all staff is following all client behavior support plans as written. The QIP will visit the home at least weekly to ensure that adequate staffing levels are in place in the home and that all staff is following all client behavior</p>				

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	BDDS report indicated the interdisciplinary team met the client's parents/guardians and instituted restrictive measures in an effort to keep the client safe. "It was decided that [client A] was to have no contact with friends or family for 90 days and no phone use at all. The team unpacked all of her items together to look for phones. Ipad's (sic) IPod's (sic) or any item that could be used to contact friends or family. A cell phone was found in one of her bags and taken away by family and given to RM (Residential Manager) to keep locked in the office. It was also discussed [client A] is not allowed to shut her bedroom door (if she needs to change her clothes she can use the bathroom located right next to her room), she must have curtains on her window, she is allowed an IPod with no internet access, she cannot go in other clients (sic) bedrooms or in the office (except during med pass). The team will look into a security device to notify staff when her window has been opened and will be sure to get it approved by HRC (Human Rights Committee) before beginning use. Her BSP (Behavior Support Plan) will be adjusted to reflect non-compliance, cursing, arguing, and recent elopement. Staff will be trained on all updates...Team is looking into getting [client A] in to see the psychiatrist at the next available appointment and		support plans as written.  <b>Completion date: 7.23.15</b>	

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	<p>discussing therapy options at this time."</p> <p>3. A BDDS report dated 6/17/15 indicated client A had eloped from the facility on 6/16/15 at 4:00 PM. The BDDS report indicated client A "...ran outside and jumped into the a black van and quickly pulled away...." The "Plan to Resolve" component of the BDDS report indicated: "The team and [City] Police were notified immediately. A missing persons report was filed and the guardians were informed of the incident. The family has contacted the [city where client used to live] Police and the detective who had located her (client A) during the last incident....The police are aware of the address where she was previously found, the name of the boyfriend she was with, and they will check the location frequently."</p> <p>The facility's 6/16-22/15 investigation into client A's elopement of 6/16/15 was reviewed on 6/22/15 at 3:08 PM. The investigation indicated information from the staff who was assigned as the 1:1 staff (staff #3) on 6/16/15. Staff #3 indicated she was watching clients A and B sunbathing on 6/16/15 from 3:15 PM until 4:00 PM. They were lying in the driveway while staff #3 was preparing for dinner. Staff #3 had been between the kitchen and the garage while checking on</p>			

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	<p>clients A and B outside with the rest of the clients inside (C, D, E and F). Staff #4 had come in five minutes early and went inside the facility to clock in for her shift (which started at 4:00 PM) and continue the meal preparation. Staff #3 went to the garage to observe clients A and B in the driveway sunbathing. Staff #3 reported that "all of a sudden she saw [client A] stand up and run. She called to the staff inside for help and followed after her. She said [client A] jumped into a black van that pulled away too quickly to get the license plate....Police officers arrived at the scene and a missing persons report was filed. [Staff #3] reports that she could not see the van pull up because it came from the back of the house and stopped closer to the back yard. With staff vehicle in the driveway and [staff #3] standing in the garage where (staff #3 was standing) was at an angle she could not see the van. [Staff #3] also reports that she does not know how [client A] planned to leave the home, she has not seen her with a cell phone. She does not know where [client A] is going or who she was with. [Staff #3] states she has been trained on [client A's] BSP and she was less than a few feet away during the time of the incident."</p> <p>Interview with staff #3 on 6/19/15 at 5:00 PM indicated client A was not 1:1 arms'</p>			

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	<p>reach supervision during the time of her elopement on 6/16/15 at 4:00 PM.</p> <p>The investigation indicated information from the Residential Manager, RM #1. RM #1 was home after working the overnight shift at the facility and was not there during the elopement but was notified. RM #1 "stated that she had [client A's] phone in her purse due to her parents (sic) wishes that [client A] has no access to phones due to recent elopement...[client B] stated (on the morning of 6/19/15 to RM #1) that [client A] had taken her phone back out of [RM #1's] purse the previous weekend. [RM #1] stated she had not noticed the phone missing from her purse until [client B] had told her. [RM #1] believes [client A] had planned to have someone pick her up after she had stolen her phone Sunday. She reports never seeing her with the phone or any other phone. [RM #1] reports that [client B] was told by [client A] that she was going back to [city] (where she previously eloped) but does not know who she was with."</p> <p>Interview with RM #1 on 6/19/15 at 3:37 PM indicated client A had been sitting at the desk in the medication/office room of the facility on Sunday 6/14/15 and refused redirection. The interview indicated client A's cell phone was in the</p>			

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	<p>RM's purse for safe keeping and according to the guardian's wishes. The RM indicated she could not lock it up at the facility in case client A would talk new staff into giving it to her. RM #1 indicated client A must have gotten the cell phone out of her purse on Sunday during the medication administration; and during the elopement, client A was not 1:1 as defined in her BSP.</p> <p>The 6/16-22/15 investigation's conclusions were as follows: "It can be concluded that staff was not following (the) BSP correctly. Although staff were within a few feet of (the) client, they were not within arms (sic) length. (The) BSP was in the process of being adjusted to have (the) client within line of sight but had not been changed yet...it was assumed that [client A] planned to run away after stealing her phone back from Residential Manager but it can not be proven. Current location of (the) client is still unknown and it has not been determined who client left with or who she is with currently."</p> <p>Review (6/19/15 3:45 PM) of client A's 4/06/15 Individual Support Plan/ISP and 4/13/15 Behavior Support Plan/BSP indicated she had a history and targeted behavior of elopement. Elopement was "defined as leaving a location without</p>			

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	<p>permission and staff are not able to see her or do not know where she is during the behavior."</p> <p>The BSP contained the following, "Rights restrictions: 1:1 (one to one staffing) and Eyeview (sic) definitions: [Client A] will now be 1:1 during waking hours. 1:1 is defined here as staff being within arms' reach from [client A] as long as he is awake. Staff will follow [client A] anywhere is (sic) goes and stay within this radius. [Client A] will be within eye view while she is asleep. This means that staff must be able to see her at all times while she is asleep but the distance can be increased from arm view (sic) to any distance as long as she is still visible. Immediately when she wakes up staff must come back to within arms' reach and start the 1:1 back again. Phone Calls:... [Client A] will be restricted from having access to cellphones (sic) or any other devices that could connect to the internet and give her access to individuals that she is not allowed to be contacting..."</p> <p>Interview with Clinical Supervisor #1 and QIDP/Qualified Intellectual Disabilities Professional #5 on 6/22/15 at 3:15 PM indicated client A needs constant guidance due to her</p>			

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	<p>non-compliance and poor decision making. The interview indicated the client's BSP had not been followed due to a lack of staff at the time of the incident and the fact that the client was able to obtain a cell phone. QIDP #5 stated "[Client A] is street smart" but is vulnerable to sexual and financial exploitation.</p> <p>Interview with QIDP #5 on 6/22/15 at 9:00 AM and on 6/23/15 at 9:45 AM indicated client A had not yet returned to the facility after eloping on 6/16/15.</p> <p>The "Abuse/Neglect/Exploitation Policy and Procedure" component of the agency's 08/01/07 Operational Policy and Procedure Manual (revised 01/09/2015) was reviewed on 6/22/2015 at 2:35 PM. The review indicated the agency prohibited staff neglect of clients and corrections were to be implemented if allegations were substantiated. The definition of neglect was as follows:</p> <p>"F. Neglect--Program Implementation/Intervention Definition:</p> <ol style="list-style-type: none"> <li>1. Failure to provide goods and/or services necessary for the individual to avoid physical harm.</li> <li>2. Intentional failure to implement a support plan, inappropriate application</li> </ol>			

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W 0157  Bldg. 00	<p>intervention, etc. which may result in jeopardy without qualified person notification/review."</p> <p>This federal tag relates to complaint #IN00175974.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review and interview for 3 of 10 reportable incident reports reviewed, the facility failed for 1 of 3 sampled clients (A), to implement effective corrective measures to ensure client A did not elope from the facility after a pattern of elopement was established.</p> <p>Findings include:</p> <p>Observations were conducted at the facility on 6/19/15 from 2:25 PM until 6:10 PM. Client A was absent from the facility. There was no alarm on client A's bedroom window. Residential Manager</p>			W 0157	<p><b>W157:</b> If the alleged violation is verified, appropriate corrective action must be taken.</p> <p><b>Corrective Action: (specific):</b> <b>Client A is no longer in the home. The Residential Manager will be in-serviced on ensuring proper staffing levels are followed according to the schedule and client behavior support plans and needs. The Direct Care staff will be in-serviced on all client behavior support plans</b></p>		07/23/2015

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	<p>#1 indicated (6/19/15 at 3:00 PM) client A could disengage an alarm if one was attached on the window so she had client A move her desk in front of the window.</p> <p>Review of reportable incidents, BDDS reports (Bureau of Developmental Disabilities Services) and investigations on 6/19/15 at 4:45 PM and on 6/22/15 at 12:00 PM and 3:08 PM indicated the following:</p> <p>1. A BDDS report dated 5/28/15 indicated client A had eloped from her parents' care (guardians) while visiting her mother in the hospital on 5/27/15 at 7:00 AM. The report indicated client A's father had called the facility to arrange her going back to the group home on the afternoon of 5/27/15 from a leave of absence. Client A "had run away with a guy" instead. The police were contacted and commenced a search.</p> <p>2. A BDDS report dated 6/8/15 indicated client A was found by the police on 6/7/15 at 6:00 PM. Client A "had eloped from her parents (sic) care and was living with an unidentified male...." The report indicated the police removed her from the situation. The client's parents packed up her belongings and returned her to the group home. "[Client A] was visibly upset, screaming profanities at staff and</p>		<p><b>How others will be identified:</b> <b>(Systemic):</b> All client behavior plans will be reviewed to ensure that supports are in place as indicated. The Residential Manager will visit the home at least five times weekly to ensure that adequate staffing levels are in place in the home and that all staff is following all client behavior support plans as written. The QIP will visit the home at least weekly to ensure that adequate staffing levels are in place in the home and that all staff is following all client behavior support plans as written.</p> <p><b>Measures to be put in place:</b> <b>Client A is no longer in the home. The Residential Manager will be in-serviced on ensuring proper staffing levels are followed according to the schedule and client behavior support plans and needs. The Direct Care staff will be in-serviced on all client behavior support plans</b></p> <p><b>Monitoring of Corrective Action:</b> All client behavior plans will be reviewed to ensure that supports are in place as indicated. The Residential Manager will visit the home at least five times weekly to ensure that adequate staffing levels are in place in the home and that all staff is following all client behavior support plans as written. The QIP</p>		

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	<p>family, and making more threats to leave."</p> <p>The "Plan to Resolve" component of the BDDS report indicated the interdisciplinary team met the client's parents/guardians and instituted restrictive measures in an effort to keep the client safe. "It was decided that [client A] was to have no contact with friends or family for 90 days and no phone use at all. The team unpacked all of her items together to look for phones. Ipad's (sic) IPod's (sic) or any item that could be used to contact friends or family. A cell phone was found in one of her bags and taken away by family and given to RM (Residential Manager) to keep locked in the office. It was also discussed [client A] is not allowed to shut her bedroom door (if she needs to change her clothes she can use the bathroom located right next to her room), she must have curtains on her window, she is allowed an IPod with no internet access, she cannot go in other clients (sic) bedrooms or in the office (except during med pass). The team will look into a security device to notify staff when her window has been opened and will be sure to get it approved by HRC (Human Rights Committee) before beginning use. Her BSP (Behavior Support Plan) will be adjusted to reflect non-compliance, cursing, arguing, and recent elopement. Staff will be trained on</p>		<p>will visit the home at least weekly to ensure that adequate staffing levels are in place in the home and that all staff is following all client behavior support plans as written.</p> <p><b>Completion date: 7.23.15</b></p>				

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	<p>all updates...Team is looking into getting [client A] in to see the psychiatrist at the next available appointment and discussing therapy options at this time."</p> <p>3. A BDDS report dated 6/17/15 indicated client A had eloped from the facility on 6/16/15 at 4:00 PM. The BDDS report indicated client A "...ran outside and jumped into the a black van and quickly pulled away...." The "Plan to Resolve" component of the BDDS report indicated: "The team and [City] Police were notified immediately. A missing persons report was filed and the guardians were informed of the incident. The family has contacted the [city where client used to live] Police and the detective who had located her (client A) during the last incident....The police are aware of the address where she was previously found, the name of the boyfriend she was with, and they will check the location frequently."</p> <p>The facility's 6/16-22/15 investigation into client A's elopement of 6/16/15 was reviewed on 6/22/15 at 3:08 PM. The investigation indicated information from the staff who was assigned as the 1:1 staff (staff #3) on 6/16/15. Staff #3 indicated she was watching clients A and B sunbathing on 6/16/15 from 3:15 PM until 4:00 PM. They were lying in the</p>			

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	<p>driveway while staff #3 was preparing for dinner. Staff #3 had been between the kitchen and the garage while checking on clients A and B outside with the rest of the clients inside (C, D, E and F). Staff #4 had come in five minutes early and went inside the facility to clock in for her shift (which started at 4:00 PM) and continue the meal preparation. Staff #3 went to the garage to observe clients A and B in the driveway sunbathing. Staff #3 reported that "all of a sudden she saw [client A] stand up and run. She called to the staff inside for help and followed after her. She said [client A] jumped into a black van that pulled away too quickly to get the license plate....Police officers arrived at the scene and a missing persons report was filed. [Staff #3] reports that she could not see the van pull up because it came from the back of the house and stopped closer to the back yard. With staff vehicle in the driveway and [staff #3] standing in the garage where (staff #3 was standing) was at an angle she could not see the van. [Staff #3] also reports that she does not know how [client A] planned to leave the home, she has not seen her with a cell phone. She does not know where [client A] is going or who she was with. [Staff #3] states she has been trained on [client A's] BSP and she was less than a few feet away during the time of the incident."</p>			

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	<p>The investigation indicated information from the Residential Manager, RM #1. RM #1 was home after working the overnight shift at the facility and was not there during the elopement but was notified. RM #1 "stated that she had [client A's] phone in her purse due to her parents (sic) wishes that [client A] has no access to phones due to recent elopement...[client B] stated (on the morning of 6/19/15 to RM #1) that [client A] had taken her phone back out of [RM #1's] purse the previous weekend. [RM #1] stated she had not noticed the phone missing from her purse until [client B] had told her. [RM #1] believes [client A] had planned to have someone pick her up after she had stolen her phone Sunday. She reports never seeing her with the phone or any other phone. [RM #1] reports that [client B] was told by [client A] that she was going back to [city] (where she previously eloped) but does not know who she was with."</p> <p>The 6/16-22/15 investigation's conclusions were as follows: "It can be concluded that staff was not following (the) BSP correctly. Although staff were within a few feet of (the) client, they were not within arms (sic) length. (The) BSP was in the process of being adjusted to have (the) client within</p>			

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	<p>line of sight but had not been changed yet...it was assumed that [client A] planned to run away after stealing her phone back from Residential Manager but it can not be proven. Current location of (the) client is still unknown and it has not been determined who client left with or who she is with currently."</p> <p>Review (6/19/15 3:45 PM) of client A's 4/06/15 Individual Support Plan/ISP and 4/13/15 Behavior Support Plan/BSP indicated she had a history and targeted behavior of elopement. Elopement was "defined as leaving a location without permission and staff are not able to see her or do not know where she is during the behavior."</p> <p>The BSP contained the following, "Rights restrictions: 1:1 (one to one staffing) and Eyeview (sic) definitions: [Client A] will now be 1:1 during waking hours. 1:1 is defined here as staff being within arms' reach from [client A] as long as he is awake. Staff will follow [client A] anywhere is (sic) goes and stay within this radius. [Client A] will be within eye view while she is asleep. This means that staff must be able to see her at all times while she is asleep but the distance can be increased from arm view (sic) to any distance as long as she is still visible.</p>			

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	<p>Immediately when she wakes up staff must come back to within arms' reach and start the 1:1 back again.</p> <p>Phone Calls:...</p> <p>[Client A] will be restricted from having access to cellphones (sic) or any other devices that could connect to the internet and give her access to individuals that she is not allowed to be contacting..."</p> <p>Facility staff's time cards for 6/13/15 through 6/16/15 were reviewed and Clinical Supervisor/CS #1 was interviewed on 6/22/15 at 1:45 PM. The review/interview indicated staff #3 had worked alone at the facility on 6/13/15 from 12:00 AM until 8:00 AM with clients A, B, C, D, E, and F. Staff #6 worked the nightshift alone with the clients on 6/13/15 from 11:00 PM until 8:00 AM on 6/14/15. RM #1 worked alone with the clients on 6/14/15 from 11:00 PM until 6:00 AM on 6/15/15. On 6/15/15 from 10:00 PM until 6:00 AM on 6/16/15, staff #7 had worked alone with the clients. CS #1 indicated staff #3 had worked alone with clients A, B, C, D, E and F on 6/16/15 from 3:15 PM until 4:00 PM because they had arrived back early to the facility from day programs. The record review and interview indicated there was not sufficient staff to implement the 1:1 supervision protocol according to client A's 4/13/15 BSP.</p>			

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	<p>Interview with RM #1 on 6/19/15 at 3:37 PM indicated client A had been sitting at the desk in the medication/office room of the facility on Sunday 6/14/15 and refused redirection. The interview indicated client A's cell phone was in the RM's purse for safe keeping according to the guardian's wishes. The RM indicated she could not lock it up at the facility in case client A would talk new staff into giving it to her. RM #1 indicated client A must have gotten the cell phone out of her purse on Sunday during the medication administration; and during the elopement, client A was not 1:1 supervision as defined in her BSP. Client A had a cell phone which was not according to the revisions in her behavior plan or the 6/8/15 BDDS report's plan to resolve component.</p> <p>Interview with staff #3 on 6/19/15 at 5:00 PM indicated client A was not 1:1 arms' reach supervision during the time of her elopement on 6/16/15 at 4:00 PM.</p> <p>Interview with Clinical Supervisor/CS #1 and QIDP/Qualified Intellectual Disabilities Professional #5 on 6/22/15 at 3:15 PM indicated client A needs constant guidance due to her non-compliance and poor decision making. The interview indicated the</p>			

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W 0186 Bldg. 00	<p>client's BSP had not been followed due to a lack of staff at the time of the incident and the fact that the client was able to obtain a cell phone. The "Plan to Resolve" component of the 6/8/15 BDDS report had not been implemented. QIDP #5 stated "[Client A] is street smart" but is vulnerable to sexual and financial exploitation. Interview with QIDP #5 on 6/22/15 at 9:00 AM and on 6/23/15 at 9:45 AM indicated client A had not yet returned to the facility after eloping on 6/16/15.</p> <p>This federal tag relates to complaint #IN00175974.</p> <p>9-3-2(a)</p> <p>483.430(d)(1-2) DIRECT CARE STAFF 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>			

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	<p>Based on observation, record review and interview for 1 of 10 reportable incident reports reviewed, the facility failed for 1 of 3 sampled clients (A), to ensure sufficient staff were available to implement client A's behavior management protocol and prevent her from eloping after a pattern of elopement was established.</p> <p>Findings include:</p> <p>Observations were conducted at the facility on 6/19/15 from 2:25 PM until 6:10 PM. Client A was absent from the facility.</p> <p>Review of reportable incidents, BDDS reports (Bureau of Developmental Disabilities Services) and investigations on 6/19/15 at 4:45 PM and on 6/22/15 at 12:00 PM and 3:08 PM indicated the following:</p> <p>1. A BDDS report dated 5/28/15 indicated client A had eloped from her parents' care (guardians) while visiting her mother in the hospital on 5/27/15 at 7:00 AM. The report indicated client A's father had called the facility to arrange her going back to the group home on the afternoon of 5/27/15 from a leave of absence. Client A "had run away with a guy" instead. The police were contacted</p>	W 0186	<p><b>W186:</b> The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p><b>Corrective Action: (specific):</b> <b>Client A is no longer in the home. The Residential Manager will be in-serviced on ensuring proper staffing levels are followed according to the schedule and client behavior support plans and needs. The Direct Care staff will be in-serviced on all client behavior support plans</b></p> <p><b>How others will be identified: (Systemic):</b> All client behavior plans will be reviewed to ensure that supports are in place as indicated. The Residential Manager will visit the home at least five times weekly to ensure that adequate staffing levels are in place in the home and that all staff is following all client behavior support plans as written. The QIP will visit the home at least weekly to ensure that adequate staffing levels are in place in the home and that all staff is following all client behavior support plans as written.</p> <p><b>Measures to be put in place:</b></p>	07/23/2015			

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	<p>and commenced a search.</p> <p>2. A BDDS report dated 6/8/15 indicated client A was found by the police on 6/7/15 at 6:00 PM. Client A "had eloped from her parents (sic) care and was living with an unidentified male...." The report indicated the police removed her from the situation. The client's parents packed up her belongings and returned her to the group home. "[Client A] was visibly upset, screaming profanities at staff and family, and making more threats to leave."</p> <p>The "Plan to Resolve" component of the BDDS report indicated the interdisciplinary team met the client's parents/guardians and instituted restrictive measure in an effort to keep the client safe. "It was decided that [client A] was to have no contact with friends or family for 90 days and no phone use at all. The team unpacked all of her items together to look for phones. IPad's (sic) IPod's (sic) or any item that could be used to contact friends or family. A cell phone was found in one of her bags and taken away by family and given to RM (Residential Manager) to keep locked in the office. It was also discussed [client A] is not allowed to shut her bedroom door (if she needs to change her clothes she can use the bathroom located right next to her room), she must have curtains on</p>		<p><b>Client A is no longer in the home. The Residential Manager will be in-serviced on ensuring proper staffing levels are followed according to the schedule and client behavior support plans and needs. The Direct Care staff will be in-serviced on all client behavior support plans</b></p> <p><b>Monitoring of Corrective Action:</b> All client behavior plans will be reviewed to ensure that supports are in place as indicated. The Residential Manager will visit the home at least five times weekly to ensure that adequate staffing levels are in place in the home and that all staff is following all client behavior support plans as written. The QIP will visit the home at least weekly to ensure that adequate staffing levels are in place in the home and that all staff is following all client behavior support plans as written.</p> <p><b>Completion date: 7.23.15</b></p>				

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	<p>her window, she is allowed an IPod with no internet access, she cannot go in other clients (sic) bedrooms or in the office (except during med pass). The team will look into a security device to notify staff when her window has been opened and will be sure to get it approved by HRC (Human Rights Committee) before beginning use. Her BSP (Behavior Support Plan) will be adjusted to reflect non-compliance, cursing, arguing, and recent elopement. Staff will be trained on all updates...Team is looking into getting [client A] in to see the psychiatrist at the next available appointment and discussing therapy options at this time."</p> <p>3. A BDDS report dated 6/17/15 indicated client A had eloped from the facility on 6/16/15 at 4:00 PM. The BDDS report indicated client A "...ran outside and jumped into the a black van and quickly pulled away..." The "Plan to Resolve" component of the BDDS report indicated: "The team and [City] Police were notified immediately. A missing persons report was filed and the guardians were informed of the incident. The family has contacted the [city where client used to live] Police and the detective who had located her (client A) during the last incident....The police are aware of the address where she was previously found, the name of the</p>			

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	<p>boyfriend she was with, and they will check the location frequently."</p> <p>The facility's 6/16-22/15 investigation into client A's elopement of 6/16/15 was reviewed on 6/22/15 at 3:08 PM. The investigation indicated information from the staff who was assigned as the 1:1 staff (staff #3) on 6/16/15. Staff #3 indicated she was watching clients A and B sunbathing on 6/16/15 from 3:15 PM until 4:00 PM. They were lying in the driveway while staff #3 was preparing for dinner. Staff #3 had been between the kitchen and the garage while checking on clients A and B outside with the rest of the clients inside (C, D, E and F). Staff #4 had come in five minutes early and went inside the facility to clock in for her shift (which started at 4:00 PM) and continue the meal preparation. Staff #3 went to the garage to observe clients A and B in the driveway sunbathing. Staff #3 reported that "all of a sudden she saw [client A] stand up and run. She called to the staff inside for help and followed after her. She said [client A] jumped into a black van that pulled away too quickly to get the license plate....Police officers arrived at the scene and a missing persons report was filed. [Staff #3] reports that she could not see the van pull up because it came from the back of the house and stopped closer to the back</p>			

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	<p>yard. With staff vehicle in the driveway and [staff #3] standing in the garage where (staff #3 was standing) was at an angle she could not see the van. [Staff #3] also reports that she does not know how [client A] planned to leave the home, she has not seen her with a cell phone. She does not know where [client A] is going or who she was with. [Staff #3] states she has been trained on [client A's] BSP and she was less than a few feet away during the time of the incident."</p> <p>The 6/16-22/15 investigation's conclusions were as follows: "It can be concluded that staff was not following (the) BSP correctly. Although staff were within a few feet of (the) client, they were not within arms (sic) length." Staff #3 was supervising two clients outside the facility, so client A was not a 1:1 staffing ratio.</p> <p>Review (6/19/15 3:45 PM) of client A's 4/06/15 Individual Support Plan/ISP and 4/13/15 Behavior Support Plan/BSP indicated she had a history and targeted behavior of elopement. Elopement was "defined as leaving a location without permission and staff are not able to see her or do not know where she is during the behavior." The BSP contained the following, "Rights restrictions:</p>			

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	<p>1:1 (one to one staffing) and Eyeview (sic) definitions: [Client A] will now be 1:1 during waking hours. 1:1 is defined here as staff being within arms' reach from [client A] as long as he is awake. Staff will follow [client A] anywhere is (sic) goes and stay within this radius. [Client A] will be within eye view while she is asleep. This means that staff must be able to see her at all times while she is asleep but the distance can be increased from arm view (sic) to any distance as long as she is still visible. Immediately when she wakes up staff must come back to within arms' reach and start the 1:1 back again."</p> <p>Facility staff's time cards for 6/13/15 through 6/16/15 were reviewed and Clinical Supervisor/CS #1 was interviewed on 6/22/15 at 1:45 PM. The review/interview indicated staff #3 had worked alone at the facility on 6/13/15 from 12:00 AM until 8:00 AM with clients A, B, C, D, E, and F. Staff #6 worked the nightshift alone with the clients on 6/13/15 from 11:00 PM until 8:00 AM on 6/14/15. RM #1 worked alone with the clients on 6/14/15 from 11:00 PM until 6:00 AM on 6/15/15. On 6/15/15 from 10:00 PM until 6:00 AM on 6/16/15, staff #7 had worked alone with the clients. CS #1 indicated staff #3 had</p>						

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	<p>worked alone with clients A, B, C, D, E and F on 6/16/15 from 3:15 PM until 4:00 PM because they had arrived back early to the facility from day programs. The record view and interview indicated there was not sufficient staff to implement the 1:1 protocol according to client A's 4/13/15 BSP.</p> <p>Interview with RM #1 on 6/19/15 at 3:37 PM indicated client A was not 1:1 supervision as defined in her BSP.</p> <p>Interview with staff #3 on 6/19/15 at 5:00 PM indicated client A was not 1:1 arms' reach supervision during the time of her elopement on 6/16/15 at 4:00 PM.</p> <p>Interview with Clinical Supervisor/CS #1 and QIDP/Qualified Intellectual Disabilities Professional #5 on 6/22/15 at 3:15 PM indicated client A needs constant guidance due to her non-compliance and poor decision making. The interview indicated the client's BSP had not been followed due to a lack of staff at the time of the incident and the fact that the client was able to obtain a cell phone. The "Plan to Resolve" component of the 6/8/15 BDDS report had not been implemented. QIDP #5 stated "[Client A] is street smart" but is vulnerable to sexual and financial exploitation. Interview with QIDP #5 on</p>			

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W 0249 Bldg. 00	<p>6/22/15 at 9:00 AM and on 6/23/15 at 9:45 AM indicated client A had not yet returned to the facility after eloping on 6/16/15.</p> <p>This federal tag relates to complaint #IN00175974.</p> <p>9-3-3(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (A), the facility failed to implement the client's Behavior Management Protocols effectively to prevent elopement from the facility after a pattern of elopement was established.</p> <p>Findings include:</p>	W 0249	<p><b>W249: As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the</b></p>	07/23/2015

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	<p>Observations were conducted at the facility on 6/19/15 from 2:25 PM until 6:10 PM. Client A was absent from the facility. There was no alarm on client A's bedroom window. Residential Manager #1 indicated (6/19/15 at 3:00 PM) client A could disengage an alarm if one was attached on the window so she had client A move her desk in front of the window.</p> <p>Review of reportable incidents, BDDS reports (Bureau of Developmental Disabilities Services) and investigations on 6/19/15 at 4:45 PM and on 6/22/15 at 12:00 PM and 3:08 PM indicated the following:</p> <ol style="list-style-type: none"> <li>1. A BDDS report dated 5/28/15 indicated client A had eloped from her parents' care (guardians) while visiting her mother in the hospital on 5/27/15 at 7:00 AM. The report indicated client A's father had called the facility to arrange her going back to the group home on the afternoon of 5/27/15 from a leave of absence. Client A "had run away with a guy" instead. The police were contacted and commenced a search.</li> <li>2. A BDDS report dated 6/8/15 indicated client A was found by the police on 6/7/15 at 6:00 PM. Client A "had eloped from her parents (sic) care and was living</li> </ol>		<p><b>individual program plan.</b></p> <p><b>Corrective Action: (specific):</b> Client A is no longer in the home. The Residential Manager will be in-serviced on ensuring proper staffing levels are followed according to the schedule and client behavior support plans and needs. The Direct Care staff will be in-serviced on all client behavior support plans</p> <p><b>How others will be identified: (Systemic):</b> All client behavior plans will be reviewed to ensure that supports are in place as indicated. The Residential Manager will visit the home at least five times weekly to ensure that adequate staffing levels are in place in the home and that all staff is following all client behavior support plans as written. The QIP will visit the home at least weekly to ensure that adequate staffing levels are in place in the home and that all staff is following all client behavior support plans as written.</p> <p><b>Measures to be put in place:</b> Client A is no longer in the home. The Residential Manager will be in-serviced on ensuring proper staffing levels are followed according to the schedule and</p>		

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	<p>with an unidentified male...." The report indicated the police removed her from the situation. The client's parents packed up her belongings and returned her to the group home. "[Client A] was visibly upset, screaming profanities at staff and family, and making more threats to leave."</p> <p>The "Plan to Resolve" component of the BDDS report indicated the interdisciplinary team met the client's parents/guardians and instituted restrictive measures in an effort to keep the client safe. "It was decided that [client A] was to have no contact with friends or family for 90 days and no phone use at all. The team unpacked all of her items together to look for phones. Ipad's (sic) IPod's (sic) or any item that could be used to contact friends or family. A cell phone was found in one of her bags and taken away by family and given to RM (Residential Manager) to keep locked in the office. It was also discussed [client A] is not allowed to shut her bedroom door (if she needs to change her clothes she can use the bathroom located right next to her room), she must have curtains on her window, she is allowed an IPod with no internet access, she cannot go in other clients (sic) bedrooms or in the office (except during med pass). The team will look into a security device to notify staff when her window has been opened and</p>		<p><b>client behavior support plans and needs. The Direct Care staff will be in-serviced on all client behavior support plans</b></p> <p><b>Monitoring of Corrective Action:</b> All client behavior plans will be reviewed to ensure that supports are in place as indicated. The Residential Manager will visit the home at least five times weekly to ensure that adequate staffing levels are in place in the home and that all staff is following all client behavior support plans as written. The QIP will visit the home at least weekly to ensure that adequate staffing levels are in place in the home and that all staff is following all client behavior support plans as written.</p> <p><b>Completion date: 7.23.15</b></p>	

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	<p>will be sure to get it approved by HRC (Human Rights Committee) before beginning use. Her BSP (Behavior Support Plan) will be adjusted to reflect non-compliance, cursing, arguing, and recent elopement. Staff will be trained on all updates...Team is looking into getting [client A] in to see the psychiatrist at the next available appointment and discussing therapy options at this time."</p> <p>3. A BDDS report dated 6/17/15 indicated client A had eloped from the facility on 6/16/15 at 4:00 PM. The BDDS report indicated client A "...ran outside and jumped into the (sic) a black van and quickly pulled away...." The "Plan to Resolve" component of the BDDS report indicated: "The team and [City] Police were notified immediately. A missing persons report was filed and the guardians were informed of the incident. The family has contacted the [city where client used to live] Police and the detective who had located her (client A) during the last incident...The police are aware of the address where she was previously found, the name of the boyfriend she was with, and they will check the location frequently."</p> <p>The facility's 6/16-22/15 investigation into client A's elopement of 6/16/15 was reviewed on 6/22/15 at 3:08 PM.</p>			

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	<p>The investigation indicated information from the staff who was assigned as the 1:1 staff (staff #3) on 6/16/15. Staff #3 indicated she was watching clients A and B sunbathing on 6/16/15 from 3:15 PM until 4:00 PM. They were lying in the driveway while staff #3 was preparing for dinner. Staff #3 had been between the kitchen and the garage while checking on clients A and B outside with the rest of the clients inside (C, D, E and F). Staff #4 had come in five minutes early and went inside the facility to clock in for her shift (which started at 4:00 PM) and continue the meal preparation. Staff #3 went to the garage to observe clients A and B in the driveway sunbathing. Staff #3 reported that "all of a sudden she saw [client A] stand up and run. She called to the staff inside for help and followed after her. She said [client A] jumped into a black van that pulled away too quickly to get the license plate....Police officers arrived at the scene and a missing persons report was filed. [Staff #3] reports that she could not see the van pull up because it came from the back of the house and stopped closer to the back yard. With staff vehicle in the driveway and [staff #3] standing in the garage where (staff #3 was standing) was at an angle she could not see the van. [Staff #3] also reports that she does not know how [client A] planned to leave the</p>			

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	<p>home, she has not seen her with a cell phone. She does not know where [client A] is going or who she was with. [Staff #3] states she has been trained on [client A's] BSP and she was less than a few feet away during the time of the incident."</p> <p>The investigation indicated information from the Residential Manager, RM #1. RM #1 was home after working the overnight shift at the facility and was not there during the elopement but was notified. RM #1 "stated that she had [client A's] phone in her purse due to her parents (sic) wishes that [client A] has no access to phones due to recent elopement...[client B] stated (on the morning of 6/19/15 to RM #1) that [client A] had taken her phone back out of [RM #1's] purse the previous weekend. [RM #1] stated she had not noticed the phone missing from her purse until [client B] had told her. [RM #1] believes [client A] had planned to have someone pick her up after she had stolen her phone Sunday. She reports never seeing her with the phone or any other phone. [RM #1] reports that [client B] was told by [client A] that she was going back to [city] (where she previously eloped) but does not know who she was with."</p> <p>The 6/16-22/15 investigation's conclusions were as follows:</p>			

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	<p>"It can be concluded that staff was not following (the) BSP correctly. Although staff were within a few feet of (the) client, they were not within arms (sic) length. (The) BSP was in the process of being adjusted to have (the) client within line of sight but had not been changed yet...it was assumed that [client A] planned to run away after stealing her phone back from Residential Manager but it can not be proven. Current location of (the) client is still unknown and it has not been determined who client left with or who she is with currently."</p> <p>Review (6/19/15 3:45 PM) of client A's 4/06/15 Individual Support Plan/ISP and 4/13/15 Behavior Support Plan/BSP indicated she had a history and targeted behavior of elopement. Elopement was "defined as leaving a location without permission and staff are not able to see her or do not know where she is during the behavior." The BSP contained the following, "Rights restrictions: 1:1 (one to one staffing) and Eyeview (sic) definitions: [Client A] will now be 1:1 during waking hours. 1:1 is defined here as staff being within arms' reach from [client A] as long as he is awake. Staff will follow [client A] anywhere is (sic) goes and stay within this radius.</p>			

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	<p>[Client A] will be within eye view while she is asleep. This means that staff must be able to see her at all times while she is asleep but the distance can be increased from arm view (sic) to any distance as long as she is still visible. Immediately when she wakes up staff must come back to within arms' reach and start the 1:1 back again. Phone Calls:...</p> <p>[Client A] will be restricted from having access to cellphones (sic) or any other devices that could connect to the internet and give her access to individuals that she is not allowed to be contacting...."</p> <p>Facility staff's time cards for 6/13/15 through 6/16/15 were reviewed and Clinical Supervisor/CS #1 was interviewed on 6/22/15 at 1:45 PM. The review/interview indicated staff #3 had worked alone at the facility on 6/13/15 from 12:00 AM until 8:00 AM with clients A, B, C, D, E, and F. Staff #6 worked the nightshift alone with the clients on 6/13/15 from 11:00 PM until 8:00 AM on 6/14/15. RM #1 worked alone with the clients on 6/14/15 from 11:00 PM until 6:00 AM on 6/15/15. On 6/15/15 from 10:00 PM until 6:00 AM on 6/16/15, staff #7 had worked alone with the clients. CS #1 indicated staff #3 had worked alone with clients A, B, C, D, E and F on 6/16/15 from 3:15 PM until</p>			

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	<p>4:00 PM because they had arrived back early to the facility from day programs. The record view and interview indicated there was not sufficient staff to implement the 1:1 protocol according to client A's 4/13/15 BSP.</p> <p>Interview with RM #1 on 6/19/15 at 3:37 PM indicated client A had been sitting at the desk in the medication/office room of the facility on Sunday 6/14/15 and refused redirection. The interview indicated client A's cell phone was in the RM's purse for safe keeping according to the guardian's wishes. The RM indicated she could not lock it up at the facility in case client A would talk new staff into giving it to her. RM #1 indicated client A must have gotten the cell phone out of her purse on Sunday during the medication administration, and during the elopement, client A was not 1:1 supervision as defined in her BSP. Client A had a cell phone which was not according to the revisions to her behavior plan or the 6/8/15 BDDS reports plan to resolve component of remedies/corrections.</p> <p>Interview with staff #3 on 6/19/15 at 5:00 PM indicated client A was not 1:1 arms' reach supervision during the time of her elopement on 6/16/15 at 4:00 PM.</p> <p>Interview with Clinical Supervisor/CS #1</p>						

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W 0407	<p>and QIDP/Qualified Intellectual Disabilities Professional #5 on 6/22/15 at 3:15 PM indicated client A needs constant guidance due to her non-compliance and poor decision making. The interview indicated the client's BSP had not been followed due to a lack of staff at the time of the incident and the fact that the client was able to obtain a cell phone. The "Plan to Resolve" component of the 6/8/15 BDDS report had not been implemented. QIDP #5 stated "[Client A] is street smart" but is vulnerable to sexual and financial exploitation. Interview with QIDP #5 on 6/22/15 at 9:00 AM and on 6/23/15 at 9:45 AM indicated client A had not yet returned to the facility after eloping on 6/16/15.</p> <p>This federal tag relates to complaint #IN00175974.</p> <p>9-3-4(a)</p> <p>483.470(a)(1) CLIENT LIVING ENVIRONMENT</p>			

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Bldg. 00	<p>The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (client A), the facility failed to ensure the client was properly placed in regard to social, behavioral and psychiatric needs.</p> <p>Findings include:</p> <p>Observations were conducted at the facility on 6/19/15 from 2:25 PM until 6:10 PM. Client A was absent from the facility.</p> <p>Review of reportable incidents, BDDS reports (Bureau of Developmental Disabilities Services) and investigations on 6/19/15 at 4:45 PM and on 6/22/15 at 12:00 PM and 3:08 PM indicated the following:</p> <p>1. A BDDS report dated 5/28/15 indicated client A had eloped from her parents' care (guardians) while visiting her mother in the hospital on 5/27/15 at 7:00 AM. The report indicated client A's father had called the facility to arrange her going back to the group home on the afternoon of 5/27/15 from a leave of absence. Client A "had run away with a</p>	W 0407	<p><b>W407:</b> The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote growth and development of all those housed together.</p> <p><b>Corrective Action: (Specific):</b> Client A is no longer in the home. Client A has been discharged and is living with guardians. The local BDDS office is working with the guardians to secure appropriate placement for client A.</p> <p><b>How others will be identified: (Systemic):</b> The interdisciplinary team will review all referrals thoroughly to ensure that client placement is planned to promote growth and development of all clients and that the ages, developmental levels and social needs of all clients are appropriate.</p> <p><b>Measures to be put in place:</b> Client A is no longer in the home. Client A has been discharged and is living with guardians. The local BDDS office is working with the guardians</p>	07/23/2015			

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	<p>guy" instead. The police were contacted and commenced a search.</p> <p>2. A BDDS report dated 6/8/15 indicated client A was found by the police on 6/7/15 at 6:00 PM. Client A "had eloped from her parents (sic) care and was living with an unidentified male..." The report indicated the police removed her from the situation. The client's parents packed up her belongings and returned her to the group home. "[Client A] was visibly upset, screaming profanities at staff and family, and making more threats to leave."</p> <p>The "Plan to Resolve" component of the BDDS report indicated the interdisciplinary team met the client's parents/guardians and instituted restrictive measures in an effort to keep the client safe. "It was decided that [client A] was to have no contact with friends or family for 90 days and no phone use at all. The team unpacked all of her items together to look for phones. iPad's (sic) IPod's (sic) or any item that could be used to contact friends or family. A cell phone was found in one of her bags and taken away by family and given to RM (Residential Manager) to keep locked in the office. It was also discussed [client A] is not allowed to shut her bedroom door (if she needs to change her clothes she can use the bathroom located right next</p>		<p>to secure appropriate placement for client A.</p> <p><b>Monitoring of Corrective Action:</b> The interdisciplinary team will review all referrals thoroughly to ensure that client placement is planned to promote growth and development of all clients and that the ages, developmental levels and social needs of all clients are appropriate.</p> <p><b>Completion date: 7.23.15</b></p>	

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	<p>to her room), she must have curtains on her window, she is allowed an IPod with no internet access, she cannot go in other clients (sic) bedrooms or in the office (except during med pass). The team will look into a security device to notify staff when her window has been opened and will be sure to get it approved by HRC (Human Rights Committee) before beginning use. Her BSP (Behavior Support Plan) will be adjusted to reflect non-compliance, cursing, arguing, and recent elopement. Staff will be trained on all updates...Team is looking into getting [client A] in to see the psychiatrist at the next available appointment and discussing therapy options at this time."</p> <p>3. A BDDS report dated 6/17/15 indicated client A had eloped from the facility on 6/16/15 at 4:00 PM. The BDDS report indicated client A "...ran outside and jumped into the (sic) a black van and quickly pulled away...." The "Plan to Resolve" component of the BDDS report indicated: "The team and [City] Police were notified immediately. A missing persons report was filed and the guardians were informed of the incident. The family has contacted the [city where client used to live] Police and the detective who had located her (client A) during the last incident...The police are aware of the address where she was</p>			

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	<p>previously found, the name of the boyfriend she was with, and they will check the location frequently."</p> <p>The facility's 6/16-22/15 investigation into client A's elopement of 6/16/15 was reviewed on 6/22/15 at 3:08 PM. The investigation indicated information from the staff who was assigned as the 1:1 staff (staff #3) on 6/16/15. Staff #3 indicated she was watching clients A and B sunbathing on 6/16/15 from 3:15 PM until 4:00 PM. They were lying in the driveway while staff #3 was preparing for dinner. Staff #3 had been between the kitchen and the garage while checking on clients A and B outside with the rest of the clients inside (C, D, E and F). Staff #4 had come in five minutes early and went inside the facility to clock in for her shift (which started at 4:00 PM) and continue the meal preparation. Staff #3 went to the garage to observe clients A and B in the driveway sunbathing. Staff #3 reported that "all of a sudden she saw [client A] stand up and run. She called to the staff inside for help and followed after her. she said [client A] jumped into a black van that pulled away too quickly to get the license plate....Police officers arrived at the scene and a missing persons report was filed. [Staff #3] reports that she could not see the van pull up because it came from the back of the</p>			

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	<p>house and stopped closer to the back yard. With staff vehicle in the driveway and [staff #3] standing in the garage where (staff #3 was standing) was at an angle she could not see the van. [Staff #3] also reports that she does not know how [client A] planned to leave the home, she has not seen her with a cell phone. She does not know where [client A] is going or who she was with. [Staff #3] states she has been trained on [client A's] BSP and she was less than a few feet away during the time of the incident."</p> <p>Interview with staff #3 on 6/19/15 at 5:00 PM indicated client A was not 1:1 arms' reach supervision during the time of her elopement on 6/16/15 at 4:00 PM.</p> <p>The investigation indicated information from the Residential Manager, RM #1. RM #1 was home after working the overnight shift at the facility and was not there during the elopement but was notified. RM #1 "stated that she had [client A's] phone in her purse due to her parents (sic) wishes that [client A] has no access to phones due to recent elopement...[client B] stated (on the morning of 6/19/15 to RM #1) that [client A] had taken her phone back out of [RM #1's] purse the previous weekend. [RM #1] stated she had not noticed the phone missing from her purse until [client B]</p>			

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	<p>had told her. [RM #1] believes [client A] had planned to have someone pick her up after she had stolen her phone Sunday. She reports never seeing her with the phone or any other phone. [RM #1] reports that [client B] was told by [client A] that she was going back to [city] (where she previously eloped) but does not know who she was with."</p> <p>Interview with RM #1 on 6/19/15 at 3:37 PM indicated client A had been sitting at the desk in the medication/office room of the facility on Sunday 6/14/15 and refused redirection. The interview indicated client A's cell phone was in the RM's purse for safe keeping according to the guardian's wishes. The RM indicated she could not lock it up at the facility in case client A would talk new staff into giving it to her. RM #1 indicated client A must have gotten the cell phone out of her purse on Sunday during the medication administration.</p> <p>The 6/16-22/15 investigation's conclusions were as follows: "It can be concluded that staff was not following (the) BSP correctly. Although staff were within a few feet of (the) client, they were not within arms (sic) length. (The) BSP was in the process of being adjusted to have (the) client within line of sight but had not been changed</p>			

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	<p>yet...it was assumed that [client A] planned to run away after stealing her phone back from Residential Manager but it can not be proven. Current location of (the) client is still unknown and it has not been determined who client left with or who she is with currently."</p> <p>Client A's Comprehensive Functional Assessment/CFA dated 5/19/15 was reviewed on 6/22/15 at 11:30 AM. The CFA indicated client A was independent in all activities of daily living, grooming, bathing, toothbrushing, feminine hygiene, table manners, could order food in restaurants and could pay for items/knew the value of money. The client was able to dress herself and do domestic chores of cleaning, cooking and laundry. The client was independent in skill areas but lacked motivation and non-compliance was her biggest barrier to training, not a lack of skill.</p> <p>Interview with Clinical Supervisor #1 and QIDP/Qualified Intellectual Disabilities Professional #5 on 6/22/15 at 3:15 PM indicated client A needs constant guidance due to her non-compliance and poor decision making. QIDP #5 stated "[Client A] is street smart" but is vulnerable to sexual and financial exploitation. The interviews indicated client A was capable</p>			

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	<p>of planning an elopement and hiding her whereabouts by keeping her cell phone turned off or blocking the caller ID (identification) to keep anonymity. The interviews indicated client A required a higher level of behavioral supports and staff to client ratio that cannot be provided in the current placement.</p> <p>This federal tag relates to complaint #IN00175974.</p> <p>9-3-7(a)</p>			