

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G491	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2013
NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 356 E MOUND ST KNOX, IN 46534		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W000000	<p>This visit was for the investigation of Complaint #IN00128224.</p> <p>COMPLAINT #IN00128224: Substantiated, federal/state deficiencies related to the allegations are cited at W149, W153, W154, and W249.</p> <p>Dates of Survey: May 20, 21, 22, and June 6, 2013.</p> <p>Facility number: 001005 Provider number: 15G491 AIM number: 100245050</p> <p>Surveyor: Amber Bloss, QIDP</p> <p>The following deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/17/13 by Ruth Shackelford, QIDP.</p>	W000000			

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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W000149	<p>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.</p> <p>Based on record review and interview for 1 of 3 sampled clients (client A), the facility failed to implement their written policies and procedures for immediately reporting 2 of 3 injuries of unknown origin and thoroughly investigating 1 of 1 allegation of abuse.</p> <p>Findings include:</p> <p>1) On 5/21/13 at 11:00 AM, the facility's accident and injury reports were reviewed from 2/21/13 to 5/21/13. A facility injury report dated 4/12/13 indicated a bruise was discovered on Client A's "left upper inner arm" two inches (2") by one inch (1") in size. The report indicated the facility interviewed staff but the source of the injury remained unknown.</p> <p>An Accident/Injury report dated 4/26/13 indicated a bruise was discovered on Client A's "left butt cheek" two and a half inches (2 1/2") by one inch (1") in size. A follow up notation dated 4/27/13 indicated the size of the bruise had grown to the size of three inches (3") by one and three fourths inches (1 3/4 "). The notation indicated the bruise was "not yet over 3." They [staff] are to call if it gets larger." The report indicated the facility interviewed staff regarding the bruise but the source of injury remained unknown.</p> <p>On 5/21/13 at 1:30 PM, the QIDP (Qualified Intellectual Disability Professional) was interviewed and indicated the bruises on Client A discovered on 4/12/13 and 4/26/13 were not considered "injuries of unknown origin" and were</p>	W000149	<p>Clarification has been received on what constitutes an injury of unknown origin. The clarification will be used to determine if an injury needs to be reported. Staff responsible for reporting will be trained in the clarification to assure that injuries of unknown origin are reported according to the policy. The Community Supports Assistant Director will review a selections of injury reports each month to assure that injuries of unknown origin have been reported according to policy.</p> <p>Investigations will be reviewed for thoroughness by the supervisor according to the policy. The Community Supports Assistant Director will, each month, review a selection of investigations to assure that the supervisor is assuring that the investigation is complete and thorough according to policy.</p> <p>Person Responsible: Community Supports Assistant Director</p> <p>Completion Date: 7/6/13</p>	07/06/2013	

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	<p>not reported to Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) immediately. The QIDP indicated it was facility practice to only report injuries of unknown origin if they were greater than three inches (3") in size.</p> <p>On 5/21/13 at 1:40 PM, the Administrator was interviewed and indicated it was facility protocol to report injuries of unknown origin to DDARS/BDDS and APS only in circumstances when the injury is greater than three inches (3") as this would constitute a "critical injury." The Administrator indicated this was his understanding of reporting requirements in prior years.</p> <p>2) The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and reports of injury were reviewed on 5/21/13 at 12:00 PM. A BDDS report dated 4/11/13 indicated staff was assisting Client A to take a shower on the evening of 4/10/13 when she "discovered a bruise 3" x 2" (three inches by two inches) that appears to be 4 smaller bruises running together into one uneven oval shaped bruise." The report indicated when staff asked Client A how she got the bruise, Client A indicated Direct Support Professional (DSP) #1 had hit her. The report indicated Client A had a "behavioral episode" on the morning of 4/9/13. The report indicated the investigation was ongoing but the source of the bruise was still unknown. The report indicated, "the investigation has determined [DSP #1] did not hit [Client A] and the allegation is not substantiated."</p> <p>The facility's Accident/Injury Report with the attached interviews were reviewed and indicated the Residential Manager interviewed all staff who had worked with Client A in a 24 hour period prior to the discovery of the bruise. On 4/10/13,</p>				

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	<p>DSP #1 was interviewed and indicated Client A had a behavior on 4/9/13 which included yelling and threatening others at the breakfast table. DSP #1 indicated Client A "was taken to her room by staff." The interview indicated Client A was taken to her room by DSP #3 on one side of her, DSP #4 on the other side of her and DSP #1 at Client A's back. The interview indicated, "all staff were holding on to her gait belt." DSP #1 indicated Client A may have gotten the bruise during this behavioral incident.</p> <p>On 4/10/13, DSP #3 was interviewed and indicated Client A was sitting at the breakfast table on 4/9/13 when she "started yelling and threatening others. She (Client A) threatened to throw her (hot) tea. Another staff [DSP #1] took the tea away before [Client A] threw it." The interview indicated Client A then threw her milk which got on another client's pants. The interview indicated DSP #3, DSP #4, and DSP #1 "took (Client A) to her room using the gait belt." The interview indicated DSP #3 was on the right side of Client A holding the gait belt and Client A's hand. DSP #3 indicated Client A started throwing objects once in her room.</p> <p>On 4/10/13, DSP #4 was interviewed by the Residential Manager and indicated she was coming down the hall with DSP #3 when she heard the glass of milk hit the table. DSP #4 indicated she saw milk had gotten on another client's pants. DSP #4 indicated Client A "had been screaming, threatening, and cussing." DSP #4 indicated DSP #3, DSP #1 and herself "escorted [Client A] to her room." DSP #4 indicated the bruise might have been acquired during Client A's behavior.</p> <p>On 4/10/13, DSP #5 was interviewed by the Residential Manager and indicated she was</p>						

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	<p>assisting Client A with her shower on 4/10/13 at 6:30 PM when she saw the bruise on her right elbow. DSP #5 indicated she asked Client A how she got the bruise and Client A indicated "[DSP #1] did it." DSP #5 indicated she reported the bruise to the house manager.</p> <p>On 4/10/13, Client A was interviewed regarding her bruise of unknown origin. The interview indicated when asked what happened, Client A "said [DSP #1] hit me." The report indicated the Residential Manager asked Client A again later what happened and Client A indicated "[DSP #1] hit me." Client A indicated DSP #1 hit her on the side. The interview indicated Client A had no evidence of injury to her side.</p> <p>On 5/21/13 at 3:05 PM, the Administrator's investigation packet was reviewed which indicated the 4/9/13 injury of unknown origin and subsequent allegation of abuse were reported to the local police. The investigation packet indicated the local police interviewed Client A regarding the injury. The investigation indicated Client A was unable to answer many of the police officer's questions about the incident and was prone to changing the subject. The investigation indicated the officer asked Client A whether it hurt, Client A indicated "ya but I like [DSP #1], she helps me." The investigation indicated the "officer then put his hand over the bruise putting his fingers over it saying 'that is finger marks'" (sic).</p> <p>The interview packet indicated the Residential Manager and DSP #2 interviewed Client A again on 4/11/13 at 5:00 PM. When asked how she got the bruise, Client A indicated "[DSP #1]." Client A stated "I don't want [DSP #1] to come back. She is gone and she's not gonna (sic) come back. She told me to go to my room. I told her I wasn't</p>				

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	<p>going to my room. I told her to shut it." Client A indicated she didn't know where the bruise came from when asked again and indicated DSP #1 did "nothing."</p> <p>On 5/22/13 at 10:50 AM, Client A's Behavior Management Program (BMP) was reviewed. The Behavior Management Program (dated 2/7/12) was confirmed as current by the QIDP (Qualified Intellectual Disability Professional). Client A's BMP indicated Client A displayed behaviors of mood disturbances as evidenced by hallucinations, yelling, threatening others, physical aggression to herself, property destruction, physical aggression to others, confusion, and crying.</p> <p>Client A's BMP indicated when Client A begins yelling, staff are instructed to "intervene and see if they can help [Client A] solve any problem she is having. Staff will give some one on one attention, then redirect her to another activity once [Client A] is calm."</p> <p>Client A's BMP included staff instructions to address Client A's physical aggression. The BMP indicated if Client A was yelling and threatening others and could not be calmed or redirect, staff should have suggested Client A "go to her room to get her pillow." The BMP indicated if Client A went to her room, staff should have monitored her while she got her pillow. The BMP indicated staff should have asked Client A for the pillow and staff could have used the pillow to block further aggression. The BMP indicated if Client A would have not gone to her room, staff were instructed to "redirect [Client A] to her room without any hold to get her pillow.....if after 3 attempts to get [Client A] to her room to get her pillow and she refuses, or attempts physical aggression to someone, one staff will stay with [Client A] and the other staff will get the pillow and bring it to</p>			

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	<p>[Client A]." The BMP indicated "[Client A] will not be physically escorted to her room by staff at any time."</p> <p>The Behavior Reports for Client A were reviewed and indicated Client A had been escorted by staff to her room during a behavior on 1/1/13, 1/15/13, 1/29/13, 2/3/13, 2/7/13, 2/13/13, 2/27/13, and 3/10/13.</p> <p>On 5/22/13 at 10:50 AM, the QIDP was interviewed. The QIDP indicated staff followed Client A's BMP during Client A's behavior on 4/9/13 and indicated the investigation was unable to substantiate the allegation of abuse. Upon review of the BMP, the QIDP indicated she was not aware the BMP instructed staff to not escort Client A to her room. The QIDP indicated the staff were not interviewed whether they attempted to use the pillow technique as outlined in Client A's BMP. The QIDP indicated it was her responsibility to review the the Behavior Reports and indicated it was a mistake to have missed the escorts being documented in those reports.</p> <p>On 5/22/13 at 11:57 AM, the Residential Manager was interviewed. The Residential Manager (RM) indicated she assisted in the investigations. The RM indicated staff had been trained on Client A's BMP. The RM indicated she was aware staff should have been using the pillow method to assist Client A during a behavior. The RM stated staff couldn't "get to the pillow quick enough to prevent anything so the plan (BMP) needs to be updated." The RM indicated staff rarely escorted Client A to her room. The RM indicated staff escorted Client A by holding the gait belt because Client A used a walker to ambulate. The RM indicated staff were not trained to escort Client A to her room by gait belt but indicated staff had been trained in safe transfers using the gait belt. The RM indicated the</p>						

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	<p>investigation could have been more thorough by investigating the use of an escort during Client A's behavior and determining whether her BMP needed to be updated.</p> <p>On 5/21/13 at 3:08 PM, the facility ' s 10/5/11 policy on abuse, neglect, and injuries of unknown origin was reviewed. The policy indicated in the event of suspected abuse, neglect, exploitation or mistreatment of a client by staff or other individuals, an investigation will be conducted. The policy indicated " the supervisor will review the documentation and determine if the investigation has been completed thoroughly. "</p> <p>This federal tag relates to complaint #IN00128224.</p> <p>9-3-2(a)</p>			

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W000153	<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 interview and record review for 2 of 3 injuries of unknown source reviewed, the facility failed to immediately report the injuries of unknown source to the administrator and/or failed to report the injury of unknown source to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b) (5) and to Adult Protective Services (APS) per IC 12-10-3 for Client A.</p> <p>Findings include:</p> <p>On 5/21/13 at 11:00 AM, the facility's accident and injury reports were reviewed 2/21/13 to 5/21/13. A facility injury report dated 4/12/13 indicated a bruise was discovered on Client A's "left upper inner arm" two inches (2") by one inch (1") in size. The report indicated the facility interviewed staff but the source of the injury remained unknown.</p>	W000153	<p>Clarification has been received on what constitutes an injury of unknown origin. The clarification will be used to determine if an injury needs to be reported. Staff responsible for reporting will be trained in the clarification to assure that injuries of unknown origin are reported according to the policy. The Community Supports Assistant Director will review a selections of injury reports each month to assure that injuries of unknown origin have been reported according to policy.</p> <p>Person Responsible: Community Supports Assistant Director</p> <p>Completion Date: 7/6/13</p>	07/06/2013	

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	<p>An Accident/Injury report dated 4/26/13 indicated a bruise was discovered on Client A's "left butt cheek" two and a half inches (2 1/2") by one inch (1") in size. A follow up notation dated 4/27/13 indicated the size of the bruise had grown to the size of three inches (3") by one and three fourths inches (1 3/4 "). The notation indicated the bruise was "not yet over 3." They (staff) are to call if it gets larger." The report indicated the facility interviewed staff regarding the bruise but the source of injury remained unknown.</p> <p>On 5/21/13 at 1:30 PM, the QIDP (Qualified Intellectual Disability Professional) was interviewed and indicated the bruises on Client A discovered on 4/12/13 and 4/26/13 were not considered "injuries of unknown origin" and were not reported to Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) immediately. The QIDP indicated it was facility practice to only report injuries of unknown origin if they were greater than three inches (3") in size.</p> <p>On 5/21/13 at 1:40 PM, the Administrator was interviewed and stated it was facility protocol to report injuries of unknown origin to DDARS/BDDS and APS only in circumstances when the injury is greater</p>						

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	<p>than three inches (3") as this would constitute a "critical injury." The Administrator indicated this was his understanding of reporting requirements in prior years.</p> <p>This federal tag relates to complaint #IN00128224.</p> <p>9-3-2(a)</p>				

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W000154	<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, the facility failed to thoroughly investigate 1 of 1 allegation of abuse affecting 1 of 3 sampled clients (Client A).</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and reports of injury were reviewed on 5/21/13 at 12:00 PM. A BDDS report dated 4/11/13 indicated staff was assisting Client A to take a shower on the evening of 4/10/13 when she "discovered a bruise 3" x 2" (three inches by two inches) that appears to be 4 smaller bruises running together into one uneven oval shaped bruise." The report indicated when staff asked Client A how she got the bruise, Client A indicated Direct Support Professional (DSP) #1 had hit her. The report indicated Client A had a "behavioral episode" on the morning of 4/9/13. The report indicated the investigation was ongoing but the source of the bruise was still unknown. The report indicated, "the investigation has determined [DSP #1] did not hit [Client A] and the allegation is not</p>	W000154	<p>Clarification has been received on what constitutes an injury of unknown origin. The clarification will be used to determine if an injury needs to be reported. Staff responsible for reporting will be trained in the clarification to assure that injuries of unknown origin are reported according to the policy. The Community Supports Assistant Director will review a selections of injury reports each month to assure that injuries of unknown origin have been reported according to policy.</p> <p>Person Responsible: Community Supports Assistant Director</p> <p>Completion Date: 7/6/13</p>	07/06/2013			

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	<p>substantiated."</p> <p>The facility's Accident/Injury Report with the attached interviews were reviewed and indicated the Residential Manager interviewed all staff who had worked with Client A in a 24 hour period prior to the discovery of the bruise. On 4/10/13, DSP #1 was interviewed and indicated Client A had a behavior on 4/9/13 which included yelling and threatening others at the breakfast table. DSP #1 indicated Client A "was taken to her room by staff." The interview indicated Client A was taken to her room by DSP #3 on one side of her, DSP #4 on the other side of her and DSP #1 at Client A's back. The interview indicated, "all staff were holding on to her gait belt." DSP #1 indicated Client A may have gotten the bruise during this behavioral incident.</p> <p>On 4/10/13, DSP #3 was interviewed and indicated Client A was sitting at the breakfast table on 4/9/13 when she "started yelling and threatening others. She (Client A) threatened to throw her (hot) tea. Another staff [DSP #1] took the tea away before [Client A] threw it." The interview indicated Client A then threw her milk which got on another client's pants. The interview indicated DSP #3, DSP #4, and DSP #1 "took [Client A] to her room using the gait belt." The</p>						

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	<p>interview indicated DSP #3 was on the right side of Client A holding the gait belt and Client A's hand. DSP #3 indicated Client A started throwing objects once in her room.</p> <p>On 4/10/13, DSP #4 was interviewed by the Residential Manager and indicated she was coming down the hall with DSP #3 when she heard the glass of milk hit the table. DSP #4 indicated she saw milk had gotten on another client's pants. DSP #4 indicated Client A "had been screaming, threatening, and cussing." DSP #4 indicated DSP #3, DSP #1 and herself "escorted [Client A] to her room." DSP #4 indicated the bruise might have been acquired during Client A's behavior.</p> <p>On 4/10/13, DSP #5 was interviewed by the Residential Manager and indicated she was assisting Client A with her shower on 4/10/13 at 6:30 PM when she saw the bruise on her right elbow. DSP #5 indicated she asked Client A how she got the bruise and Client A indicated "[DSP #1] did it." DSP #5 indicated she reported the bruise to the house manager.</p> <p>On 4/10/13, Client A was interviewed regarding her bruise of unknown origin. The interview indicated when asked what happened, Client A "said [DSP #1] hit me." The report indicated the Residential</p>				

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	<p>Manager asked Client A again later what happened and Client A indicated "[DSP #1] hit me." Client A indicated DSP #1 hit her on the side. The interview indicated Client A had no evidence of injury to her side.</p> <p>On 5/21/13 at 3:05 PM, the Administrator's investigation packet was reviewed which indicated the 4/9/13 injury of unknown origin and subsequent allegation of abuse were reported to the local police. The investigation packet indicated the local police interviewed Client A regarding the injury. The investigation indicated Client A was unable to answer many of the police officer's questions about the incident and was prone to changing the subject. The investigation indicated the officer asked Client A whether it hurt, Client A indicated "ya but I like [DSP #1], she helps me." The investigation indicated the "officer then put his hand over the bruise putting his fingers over it saying 'that is finger marks'" (sic).</p> <p>The interview packet indicated the Residential Manager and DSP #2 interviewed Client A again on 4/11/13 at 5:00 PM. When asked how she got the bruise, Client A indicated "[DSP #1]." Client A stated "I don't want [DSP #1] to come back. She is gone and she's not</p>						

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	<p>gonna (sic) come back. She told me to go to my room. I told her I wasn't going to my room. I told her to shut it." Client A indicated she didn't know where the bruise came from when asked again and indicated DSP #1 did "nothing."</p> <p>On 5/22/13 at 10:50 AM, Client A's Behavior Management Program (BMP) was reviewed. The Behavior Management Program (dated 2/7/12) was confirmed as current by the QIDP (Qualified Intellectual Disability Professional). Client A's BMP indicated Client A displayed behaviors of mood disturbances as evidenced by hallucinations, yelling, threatening others, physical aggression to herself, property destruction, physical aggression to others, confusion, and crying.</p> <p>Client A's BMP indicated when Client A begins yelling, staff are instructed to "intervene and see if they can help [Client A] solve any problem she is having. Staff will give some one on one attention, then redirect her to another activity once [Client A] is calm."</p> <p>Client A's BMP indicated staff instructions to address Client A's physical aggression. The BMP indicated if Client A was yelling and threatening others and could not be calmed or redirect, staff</p>						

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	<p>should have suggested Client A "go to her room to get her pillow." The BMP indicated if Client A went to her room, staff should have monitored her while she got her pillow. The BMP indicated staff should have asked Client A for the pillow and staff could have used the pillow to block further aggression. The BMP indicated if Client A would have not gone to her room, staff were instructed to "redirect [Client A] to her room without any hold to get her pillow.....if after 3 attempts to get [Client A] to her room to get her pillow and she refuses, or attempts physical aggression to someone, one staff will stay with [Client A] and the other staff will get the pillow and bring it to [Client A]." The BMP indicated "[Client A] will not be physically escorted to her room by staff at any time."</p> <p>The Behavior Reports for Client A were reviewed and indicated Client A had been escorted by staff to her room during a behavior on 1/1/13, 1/15/13, 1/29/13, 2/3/13, 2/7/13, 2/13/13, 2/27/13, and 3/10/13.</p> <p>On 5/22/13 at 10:50 AM, the QIDP was interviewed. The QIDP indicated staff followed Client A's BMP during Client A's behavior on 4/9/13 and indicated the investigation was unable to substantiate the allegation of abuse. Upon review of</p>			

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	<p>the BMP, the QIDP indicated she was not aware the BMP instructed staff to not escort Client A to her room. The QIDP indicated the staff were not interviewed whether they attempted to use the pillow technique as outlined in Client A's BMP. The QIDP indicated it was her responsibility to review the the Behavior Reports and indicated it was a mistake to have missed the escorts being documented in those reports.</p> <p>On 5/22/13 at 11:57 AM, the Residential Manager was interviewed. The Residential Manager (RM) indicated she assisted in the investigations. The RM indicated staff had been trained on Client A's BMP. The RM indicated she was aware staff should have been using the pillow method to assist Client A during a behavior. The RM stated staff couldn't "get to the pillow quick enough to prevent anything so the plan (BMP) needs to be updated." The RM indicated staff rarely escorted Client A to her room. The RM indicated staff escorted Client A by holding the gait belt because Client A used a walker to ambulate. The RM indicated staff were not trained to escort Client A to her room by gait belt but indicated staff had been trained in safe transfers using the gait belt. The RM indicated the investigation could have been more thorough by investigating the</p>				

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	<p>use of an escort during Client A's behavior and determining whether her BMP needed to be updated.</p> <p>This federal tag relates to complaint #IN00128224.</p> <p>9-3-2(a)</p>				

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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 upon interview and record review, the facility failed to ensure the Behavior Management Program was implemented as written for 1 of 3 sampled clients (Client A).</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and reports of injury were reviewed on 5/21/13 at 12:00 PM. A BDDS report dated 4/11/13 indicated staff was assisting Client A to take a shower on the evening of 4/10/13 when she "discovered a bruise 3" x 2" (three inches by two inches) that appears to be 4 smaller bruises running together into one uneven oval shaped bruise." The report indicated when staff asked Client A how she got the bruise, Client A indicated Direct Support Profession (DSP) #1 had hit her. The reported indicated Client A had a "behavioral episode" on the morning of 4/9/13. The report indicated</p>	W000249	The behavior plan has been revised. Staff have been trained in the implementation of the behavior program. The QDDP will monitor the implementation of the behavior program upon visits to the facility and at least monthly to assure that it is being implemented properly. Person Responsible: QDDP Completion Date: 7/6/13	07/06/2013			

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	<p>the investigation was ongoing but the source of the bruise was still unknown. The report indicated, "the investigation has determined [DSP #1] did not hit [Client A] and the allegation is not substantiated."</p> <p>The facility's Accident/Injury Report with the attached interviews were reviewed and indicated the Residential Manager interviewed all staff whom had worked with Client A in a 24 hour period prior to the discovery of the bruise. On 4/10/13, DSP #1 was interviewed and indicated Client A had a behavior on 4/9/13 which included yelling and threatening others at the breakfast table. DSP #1 stated Client A "was taken to her room by staff." The interview indicated Client A was taken to her room by DSP #3 on one side of her, DSP #4 on the other side of her and DSP #1 at Client A's back. The interview indicated, "all staff were holding on to her gait belt." DSP #1 indicated Client A may have gotten the bruise during this behavioral incident.</p> <p>On 4/10/13, DSP #3 was interviewed and indicated Client A was sitting at the breakfast table on 4/9/13 when she "started yelling and threatening others. She (Client A) threatened to throw her (hot) tea. Another staff (DSP #1) took the tea away before [Client A] threw it." The</p>			

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	<p>interview indicated Client A then threw her milk which got on another client's pants. The interview indicated DSP #3, DSP #4, and DSP #1 "took [Client A] to her room using the gait belt." The interview indicated DSP #3 was on the right side of Client A holding the gait belt and Client A's hand. DSP #3 indicated Client A started throwing objects once in her room.</p> <p>On 4/10/13, DSP #4 was interviewed by the Residential Manager and indicated she was coming down the hall with DSP #3 when she heard the glass of milk hit the table. DSP #4 indicated she saw milk had gotten on another client's pants. DSP #4 indicated Client A "had been screaming, threatening, and cussing." DSP #4 indicated DSP #3, DSP #1 and herself "escorted [Client A] to her room." DSP #4 indicated the bruise might have been acquired during Client A's behavior.</p> <p>On 4/10/13, DSP #5 was interviewed by the Residential Manager and indicated she was assisting Client A with her shower on 4/10/13 at 6:30 PM when she saw the bruise on her right elbow. DSP #5 indicated she asked Client A how she got the bruise and Client A indicated "[DSP #1] did it." DSP #5 indicated she reported the bruise to the house manager.</p>						

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	<p>On 4/10/13, Client A was interviewed regarding her bruise of unknown origin. The interview indicated when asked what happened, Client A "said [DSP #1] hit me." The report indicated the Residential Manager asked Client A again later what happened and Client A indicated "[DSP #1] hit me." Client A indicated DSP #1 hit her on the side. The interview indicated Client A had no evidence of injury to her side.</p> <p>On 5/22/13 at 10:50 AM, Client A's Behavior Management Program (BMP) was reviewed. The Behavior Management Program (dated 2/7/12) was confirmed as current by the QIDP (Qualified Intellectual Disability Professional). Client A's BMP indicated Client A displayed behaviors of mood disturbances as evidenced by hallucinations, yelling, threatening others, physical aggression to herself, property destruction, physical aggression to others, confusion, and crying.</p> <p>Client A's BMP indicated when Client A begins yelling, staff are instructed to "intervene and see if they can help [Client A] solve any problem she is having. Staff will give some one on one attention, then redirect her to another activity once [Client A] is calm."</p>						

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	<p>Client A's BMP indicated staff instructions to address Client A's physical aggression. The BMP indicated if Client A was yelling and threatening others and could not be calmed or redirect, staff should have suggested Client A "go to her room to get her pillow." The BMP indicated if Client A went to her room, staff should have monitored her while she got her pillow. The BMP indicated staff should have asked Client A for the pillow and staff could have used the pillow to block further aggression. The BMP indicated if Client A would have not gone to her, staff were instructed to "redirect [Client A] to her room without any hold to get her pillow.....if after 3 attempts to get [Client A] to her room to get her pillow and she refuses, or attempts physical aggression to someone, one staff will stay with [Client A] and the other staff will get the pillow and bring it to [Client A]." The BMP indicated "[Client A] will not be physically escorted to her room by staff at any time."</p> <p>The Behavior Reports for Client A were reviewed and indicated Client A had been escorted by staff to her room during a behavior on 1/1/13, 1/15/13, 1/29/13, 2/3/13, 2/7/13, 2/13/13, 2/27/13, and 3/10/13.</p> <p>On 5/22/13 at 10:50 AM, the QIDP was</p>			

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	<p>interviewed. The QIDP indicated staff followed Client A's BMP during Client A's behavior on 4/9/13 and indicated the investigation was unable to substantiate the allegation of abuse. Upon review of the BMP, the QIDP indicated she was not aware the BMP instructed staff to not escort Client A to her room. The QIDP indicated the staff were not interviewed whether they attempted to use the pillow technique as outlined in Client A's BMP. The QIDP indicated it was her responsibility to review the the Behavior Reports and indicated it was a mistake to have missed the escorts being documented in those reports.</p> <p>On 5/22/13 at 11:57 AM, the Residential Manager was interviewed. The RM indicated staff had been trained on Client A's BMP. The RM indicated she was aware staff should have been using the pillow method to assist Client A during a behavior. The RM stated staff couldn't "get to the pillow quick enough to prevent anything so the plan (BMP) needs to be updated." The RM indicated staff rarely escorted Client A to her room. The RM indicated staff escorted Client A by holding the gait belt because Client A used a walker to ambulate. The RM indicated staff were not trained to escort Client A to her room by gait belt but indicated staff had been trained in safe</p>						

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	<p>transfers using the gait belt.</p> <p>This federal tag relates to complaint #IN00128224.</p> <p>9-3-4(a)</p>				