

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/03/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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W 0000 Bldg. 00	<p>This visit was for the post certification revisit to the investigation of complaint #IN00175587 conducted on June 22, 2015.</p> <p>This survey was done in conjunction with the post certification revisit to the investigation of complaint #IN00170468.</p> <p>Complaint #IN00175587: Not corrected.</p> <p>Dates of Survey: July 30, 31 and August 3, 2015.</p> <p>Facility number: 012557 Provider number: 15G791 AIM number: 201017960A</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p>			

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>Based on record review and interview for 1 of 2 sampled clients and 1 additional client (clients B and C), the facility's Governing Body neglected to exercise general operating direction to provide oversight to ensure their abuse and neglect policy was implemented in regard to preventing abuse and neglect. The facility's Governing Body neglected to immediately report allegations of neglect. The facility's Governing Body neglected to exercise general operating direction in a manner to put measures in place to prevent abuse and neglect. The facility's Governing Body neglected to provide oversight to prevent abuse and neglect of clients B and C. The facility's Governing Body neglected to exercise general operating direction in a manner to provide oversight to ensure staff showed competency in their job duties in regard to immediately reporting allegations of abuse/neglect. The facility's Governing Body neglected to take effective/sufficient corrective action to prevent abuse and neglect of clients B and C which resulted in elopement during home visit and an incarceration.</p> <p>Findings include:</p> <p>Please refer to W149: The Governing Body neglected to exercise general</p>	W 0104	<p>W 104 483.410(a)(1) GOVERNING BODY</p> <p>In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD) will review this Standard, and ensure:</p> <p>A. Oversight is provided to ensure Agency's abuse/neglect Policy is implemented at all times, to prevent abuse and neglect.</p> <p>B. Oversight to ensure all allegations of abuse or neglect are reported promptly and that staff demonstrate competency in Agency's Policy in regards to reporting allegations of abuse neglect.</p> <p>C. Measures and sufficient corrective actions are promptly put in place to prevent abuse and neglect.</p> <p>D. Investigations are consistently conducted according to this Standard and Agency Policy, including conducting a thorough investigation into any allegation of abuse or neglect.</p> <p>E. Oversight to ensure behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs.</p>	09/02/2015

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	<p>operating direction over the facility for 2 of 2 sampled clients (clients B and C), by not ensuring implementation of its written policy and procedure to prevent abuse and neglect of clients. The Governing Body neglected to conduct thorough investigations in regard to allegations of abuse and neglect.</p> <p>Please refer to W153: The Governing Body neglected to exercise general operating direction over the facility for 1 of 2 sampled clients and 1 additional client (clients B and C), to report an allegation of staff abuse and neglect immediately to the administrator.</p> <p>Please refer to W154: The Governing Body neglected to exercise general operating direction over the facility for 1 additional client (client C), to provide written evidence thorough investigations were conducted in regard to allegations of neglect.</p> <p>Please refer to W157: The Governing Body neglected to exercise general operating direction over the facility for 2 of 3 clients residing at the group home (clients B and C), to take sufficient/effective corrective measures in regard to preventing/addressing staff abuse and neglect by not ensuring oversight to ensure proper interaction</p>		<p>All current and new staff will be retrained on the following:</p> <p>i. Agency Policy and Procedure concerning abuse/neglect/exploitation of Individuals served.</p> <p>ii. Refresher training on each Individual's BSP.</p> <p>F. A Director will thoroughly train all new Program Director, QDDP, and House Managers upon employment on prompt notification to the administrator of any allegation and/or suspicion of abuse/neglect and on completing thorough and timely investigations into any allegation of abuse/neglect.</p> <p>A trained Area Director, Program Director/QDDP, Nurse, and/or Behaviorist, will be in the home at various and random times throughout the week, including shift changes and random overnight checks. These visits will be to ensure all Individuals' plans/protocol and all Agency policy and procedures are followed and staff demonstrate competency in regards to their job duties regarding preventing abuse/neglect and appropriately implementing all individuals'</p>		

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	<p>with clients and not developing protocols.</p> <p>Please refer to W159: The Governing Body neglected to exercise general operating direction over the facility for 1 additional client (client C), to develop a protocol.</p> <p>Please refer to W189: The Governing Body neglected to exercise general operating direction over the facility for 1 of 2 sampled clients and 1 additional client (clients B and C), to ensure all staff who worked with clients B and C were sufficiently trained to assure competence in regard to preventing abuse and neglect.</p> <p>This deficiency was cited on 6/22/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN000175587.</p> <p>9-3-1(a)</p>		<p>BSPs/ISPs.</p> <p>This monitoring and supervision will continue until it is evident to each Individual's IDT, the Area Director, and State Director that all Individuals are free from abuse/neglect/exploitation, that all staff have demonstrated competency in all Individuals' Plans/Protocol and in Agency abuse/neglect/exploitation policy. When this has been determined, the Area Director will revise the monitoring schedule as necessary to ensure sufficient observations in order to continue the continuity and effectiveness of this plan.</p> <p>Will be completed by: 9/2/15</p> <p>Persons Responsible: Area Director, Program Director/QDDP, Nurse, and Behaviorist</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 record review and interview, the facility neglected for 1 of 2 sampled clients and 1 additional client (clients B and C), to implement its written policy and procedure to prevent abuse and neglect of clients. The facility neglected to develop a home visit plan for client C in regards to needed supervision to prevent elopement. The facility neglected to conduct thorough investigations in regard to allegations of abuse and neglect. The facility neglected to provide services to prevent and/or address client C's behaviors from aggressing, leading to incarceration.</p> <p>Findings include:</p> <p>1. A review of the facility's records was conducted on 7/30/15 at 1:15 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports/Internal Reports (GER/IR), Daily Progress Notes and an investigation record indicated:</p>	W 0149	<p>W 149 483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD) will review this Standard, and ensure Agency's abuse/neglect Policy and Procedure is implemented at all times, to prevent abuse and neglect of Individuals served.</p> <p>1. In regards to the finding that the facility neglected to provide services to prevent client C's behaviors from aggressing, leading to incarceration, the facility did provide services to ensure the health and safety of client C and client C's housemates. Client C had an HRC approved BSP that was followed by staff during the incident. Staff followed protocol in an attempt to deescalate the Individuals' aggression. However, all attempts were unsuccessful and the individual</p>	09/02/2015

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	-BDDS report dated 6/17/15 involving client C indicated: "On 6/18/15, a staff person reported that on 6/17/15 at approximately 9:00 P.M., another staff person working at the time became upset about the suggestion that the two staff take turns doing the 5 minute checks on [client C]. They stated that this staff person was sitting at the table, jumped up from the table and started yelling insulting, mean and demeaning comments using profanity, regarding individuals who live in the home. This staff reported [client C] heard these things, and became upset herself and responded by saying things like, 'I don't want her to be my staff' and towards the staff, 'If you want us to respect you, you have to respect us.' After the investigation it was determined that the allegation was substantiated. Investigation revealed the staff was yelling abusive comments about individuals served and was using profanity while in the vicinity of an individual served. Furthermore it was determined that this staff refused to provide an individual served (client A) a snack when asked. These actions violated the Agency's Policy concerning abuse, neglect and exploitation of individuals served and the staff was terminated from employment." Further		began to engage in property destruction. Staff are trained to only intervene when an individual is engaging in property destruction if the Individual or one of their housemates' health and safety is at risk. The AD stated to the Surveyor that staff monitor the Individuals to ensure their health and safety and that the Agency can always replace Agency's broken property ; that the Agency's property is not of concern...Individual and their housemates are monitored by staff during the property destruction to ensure all Individuals' health and safety. Once Client C became physically aggressive towards others, the BSP was followed and staff applied a two person physical restraint, per Protocol. When the Individual was released per Protocol, the Individual obtained and object and began using it as a weapon threatening others. 911 was called per Protocol to ensure the health and safety of the other Individuals. Throughout the incident, he Individuals' plan was followed and the health and safety of the Individual and her housemate's was ensured per Agency Policy and Procedure, and therefore their was no indication of abuse/neglect, and therefore an investigation was not conducted in regards to this incident. After the incident resulting in Client C's incarceration, Client C's IDT met and Agency met with Sheriff's office. The IDT determined that Client C is extremely dangerous, was		

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	<p>review of the record failed to indicate all clients and all staff who worked at the group home were interviewed in regard to this incident of abuse and neglect.</p> <p>-BDDS report dated 6/21/15 involving client C indicated: "At approximately 7:00 A.M. on 6/22/15, staff called Area Director (AD) to report that [client C]'s mother called the home to state she was unable to locate [client C]. AD instructed staff to call the police. Staff followed Protocol and notified the AD. AD talked with her mother who stated she sent [client C] to the store the previous evening of 6/21/15 and had not seen her since. However, she said she thought she knew where she was, but was not there. She said she called [client C] and [client C] said she would come home. AD then instructed staff to go to her mother's home to pick up [client C]. It was later discovered that the Police went to [client C]'s mother's home but her mother did not want to file a missing person's report. AD called [Police Department] to arrange for [Facility] staff, who was waiting for [client C] outside of her mother's house to file a missing person's report. Around this time, [client C] returned home and staff transported her to the office for an emergency IDT (Inter Disciplinary Team) meeting. [Client C] told the IDT that she</p>		<p>not appropriately placed in this facility, and needed a more restrictive placement to ensure her health and safety and that of others in the community. Currently, Client C has been referred for more restrictive placement in a State Operated Facility.</p> <p>2. In regards to the 7/29/15 incident regarding an altercation between clients A and B, a thorough investigation was completed by the AD, but had not yet been completed at the time of Survey. The AD indicated to the Surveyor that he was in the midst of the investigation and was asked by the Surveyor what type of information was collected so far. The AD did not state, "... he was made aware the staff started client B's behavior by telling her she would not be going on a weekend home visit." And, the AD did not state, "... the staff told client A to go get client B's baby doll which she is very attached to and that escalated her behaviors." The AD stated that he had concern due to one statement recently taken, by one witness, alleged that a staff person told Client B in the midst of an aggressive behavior that she lost her planned home visit because of her behavior, and that this same witness alleged another staff told Client A to get Client B's baby dolls. However, after a thorough investigation, these allegations were not substantiated.</p>				

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	<p>slept at her 'boyfriend's house.' She stated she knew who he was and that she grew up with him, but hasn't seen him in a while. She stated she had sex with him, but that she used protection. The IDT agreed that for the time being, [client C] will not go on future home visits, but that her mother can visit her in her group home where there is staff supervision. IDT agreed that this can be revisited by the team in the future, and then short day home visits can be arranged with a staff person accompanying her on the visit, but no more overnight visits for the time being. AD will review with the mother [client C]'s supervision needs and how the ESN (Extensive Support Needs) program works. IDT will arrange for her to have sex ed classes. AD instructed staff to take [client C] to urgent care for evaluation and treatment for potential exposure to STDs (Sexually Transmitted Diseases). Staff will continue to follow [client C]'s current protocol and IDT will monitor her progress." Further review of the record failed to indicate a protocol was developed in regard to client C's home visits.</p> <p>-Follow up BDDS report dated 7/13/15 for an incident of elopement on 6/12/15 involving client C indicated: "[Client C] requires 24 hour supervision and is provided 24/7 line of sight supervision at</p>		<p>The facility will complete the following to ensure Protocol's are developed for home visits to ensure the Individual's served are free from abuse/neglect.</p> <p>A. Each Individual's IDT will review, develop, and implement protocol to be included in each Individuals' ISP in regards to home visits, to assist in preventing abuse/neglect when on a home visit.</p> <p>B. In the future, for all new admissions to the facility, and before they are admitted, the Individuals' IDT will assess, develop, and implement protocol to be included in each Individuals' ISP in regards to home visits, to assist in preventing abuse/neglect when on a home visit.</p> <p>C. All staff will be trained on these revisions to the Individuals' plans.</p> <p>Will be completed by: 9/2/15</p> <p>Persons Responsible: Area Director, Program Director/QDDP, and Behaviorist</p>		

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	<p>her group home. Her BSP (Behavior Support Plan)/supervision protocol at her group home is 24/7 line of sight, with 5 minute checks during private or sleeping time to ensure she does not elope, in order to ensure her health and safety. [Client C] and her IDT have agreed to suspend home visits to her mother's home for the time being, until there is a plan in place to ensure her health and safety on home visits....Furthermore, the AD talked with [client C]'s mother to explain the ESN program in detail, specifically in regards to [client C]'s need for 24/7 line-of-sight supervision. [Client C]'s IDT will meet with [client C]'s mother to explain the program and answer any questions she may have."</p> <p>-BDDS report dated 6/29/15 involving client C indicated: "On 6/29/15 at approximately 3:30 P.M., [client C]'s roommate was having a transition meeting at the home for her discharge from the program. [Client C] was in her room taking a time to her self and she started to pour her body spray all over her pants leg. Staff followed protocol and tried to redirect [client C] to use her coping skills. [Client C] started to pick away at the dry wall inside her bedroom and continued until she had torn a big hole in the wall. She then began to exhibit more extreme property</p>						

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	destruction and broke her desk into pieces and pulled down her window shades. She took the leg that she broke off her desk and went outside to the garage and started breaking the front and back windows out of the van. Staff, Area Director (AD) and State Director (SD) followed protocol and monitored [client C] to ensure her health and safety. She continued to break all of the windows on the van and trash the sides of the van with the piece of broken wood. She took a fire extinguisher from the garage, went into the back yard and shattered the glass table. Staff locked the back doors into the home but she entered the garage again and then into the home through the garage. Once in the home, [client C] started to target others and AD and SD attempted a two person hold as she hit, scratched and attempted to bite AD and SD. She slid against a wall and to the ground where AD and SD released her. [Client C] was saing (sic) things like 'So you wanna touch me huh?. You wanna put you hands on me? I'm going to show yall what I can do.' She grabbed SD's leg and refused to let go. AD assisted in removing her hands from SD's leg. AD and SD gave her space. She picked up a belt she found on the table that had two metal rings at the end, wrapped it around her hand a little and started to threaten to hit staff. AD called 911 for assistance,			

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	per protocol. [Client C] returned outside in the back of the home and AD and SD instructed staff to lock all doors to home, garage and gate, in order to contain her to the back yard. [Client C] picked up various objects such as a chair, large rock, large branch and larger pieces of broken glass. She attempted to break the home windows and demanded she be let back in the home. She tried to corner and hit maintenance coordinator and SD. She then was attempting to severely harm staff, AD, SD and maintenance coordinator who were in the back yard, with a broken piece of fence with two protruding nails, large pieces of broken glass, a broken chair, a large rock and a large branch. She threw things at staff. All staff kept their distance while monitoring her health and safety. AD informed emergency services of all activities and police arrived. She taunted police through hole in the fence and police instructed her to drop the rock and branch and to lay on the ground or she would be tazed, while pointing tazer at her. She finally complied, threw rock and branch down. Police and AD instructed her to lay on ground as instructed to avoid being tazed. She complied and was handcuffed and arrested. SD explained to officer that no charges would be pressed due to nature of the program. Police officer said the State			

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	<p>would be charging her with felony criminal mischief." Review of the record failed to indicate all staff who worked at the group home were interviewed and all clients who reside at the group home were interviewed.</p> <p>A review of client C's record was conducted on 7/31/15 at 1:50 P.M.. Review of client C's Behavioral Support Plan (BSP) dated 5/20/15 indicated:</p> <p>"BEHAVIORS TO BE DECREASED (CHALLENGING BEHAVIORS/PROBLEM BEHAVIORS: Self Injurious Behavior (SIB), Physical Aggression...Inappropriate Sexual Behavior...Stealing...Elopement:</p> <p>Self-Injurious Behavior: Using silverware to harm herself, swallowing inedible objects (screws), using her fingers to dig into a previous wound from an SIB episode. According to staff, [client C] is constantly on the lookout for objects to harm herself. This happens 4 times per month and is severe in nature. [Client C] has gone to the ER (Emergency Room) due to lacerations on her arms and neck which have led to the use of steri-strips and stitches. She has also had surgery to remove item(s) that she swallowed. The duration of the</p>				

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	<p>behavior is currently unknown.</p> <p>Physical Aggression: Towards staff and peers. [Client C] will punch people and rip their shirts. [Client C] will verbally threaten staff and peers.</p> <p>Inappropriate Sexual Behavior: Exposing herself to peer, blocking a peer from moving so she can have physical contact (for example kissing) with them, sneaking into a peer's room to engage in sexual activity with them (whether or not the peer wants to). This happens approximately 2 times per month and is severe in nature as this could lead to being charged for sexual assault.</p> <p>Stealing: Taking items that are not hers.</p> <p>Elopement: Leaving the assigned area without (1) notifying staff or responsible person of her intention to leave supervision prior to departing and/or (2) leaving the assigned area or supervision by staff after being declined permission to leave the area by staff.</p> <p>5....f. Elopement: Intervention Steps: ...If [client C] is showing signs of physical or verbal aggression of agitation and redirection is not working, staff will attempt to physically escort her back to the home or implement an approved DCI</p>			

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	<p>(crisis intervention) technique if an escort if (sic) not possible. As a last resort, staff should implement an approved DCI technique if an escort if (sic) not possible and safety becomes a concern. Agitation is described as yelling, crying, screaming, talking as if she is upset about something or someone.</p> <p>g. If staff is following [client C] and loses sight of her, they should call local law enforcement. The individual's full first name, last name, as well as middle initial, a physical description, (e.g. color and/or type of clothing last seen in, color of hair and eyes, height and weight, etc.), and the group home address should be communicated to the police....</p> <p>BEHAVIORS TO BE DECREASED (CHALLENGING BEHAVIORS/PROBLEM BEHAVIORS: Self Injurious Behavior (SIB), Physical Aggression...Elopement...Property Destruction...Refusal...Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques:</p> <p>Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques</p> <p>Less Restrictive Physical Redirection/Response</p>			

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	<p>Blocking= to change course or direction of momentum. Redirection techniques are used to take advantage of a person's momentum to redirect without holding on to the person. Response blocking is the physical intervention to stop a person's momentum during events of physical aggression without holding on to the person.</p> <p>Releasing=Gaining release from a physical hold; this may involve briefly holding to the hand or the wrist of the person.</p> <p>Walking with or accompanying/Escorting: Walking with a person to give direction, guidance, and protection from harm. Staff may use light, occasional touch or may have to use a support walk with their hand on the upper shoulder and lower arm.</p> <p>Restrictive physical interaction should only be used for the protection from harm and should be terminated as soon as the need for protection is over.</p> <p>Side Body Hug=Standing beside/slightly behind the person holding one of the arms against the person's body and your, hugging along the person's natural waist. This may be combined with another staff repeating this same hold on the other side</p>			

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	<p>of the person should a one-person hold prove to be ineffective.</p> <p>More restrictive:</p> <p>One arm Standing=Standing behind the person, holding one arm of the person in front of their body with both of your hands, hugging around the natural waistline from behind the person.</p> <p>Two Person Hold= Standing behind the person with hands in a 'c' formation at wrist with opposite arm to individual and arm closest to individual on the shoulder. Inner leg should be behind client next to their inside foot for stability. Staff on other side with the same stance, bend the person over slightly for three count then raise back up. If client drops to the floor staff is to go with them while maintaining client safety. During this procedure staff should be giving short commands to calm down, take a breath, you are safe; to the individual."</p> <p>"FOLLOW-UP:</p> <p>All of [client C]'s caregivers should be trained by his/her behavior consultant to consistently implement her behavior plan. After all staff are trained, [client C]'s behavior should be monitored by her behavior consultant on a weekly basis.</p>			

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	<p>[Client C]'s individual support team (IST) will review her BSP at least quarterly to evaluate its appropriateness." Review of the BSP failed to indicate how facility staff should intervene during property destruction to prevent client C from escalating into physical aggression.</p> <p>2. -BDDS report dated 7/28/15 involving clients A and B indicated: "On the early morning of Wednesday, July 29, [client B] was engaged in a target behavior, and was in the back yard of her home and was attempting to calm down. Her housemate came outside to ask the staff a question, and [client B] charged at her, yelling at her to go back inside. [Client B]'s housemate (client A), put her hands up to block a hit from her, and her hand hit [client B] in the left eye. As [client A] was being redirected back into the home, [client B] threw an outdoor ashtray at her. The staff spoke to [client B] and attempted to redirect her. When [client B] appeared to be calm, she went back into the house. [Client B] then locked herself up in a bathroom, and began yelling and crying that she does not like her. The staff again spoke with [client B], and she appeared to calm down. A short while later, one of [client B]'s staff left with her housemate, leaving [client B] at home with the second staff. [Client B] called her mom and then 911 and</p>			

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	<p>reported that her staff (the one present in the home with her) had hit her. The police arrived and spoke with [client B] and her staff. The police asked [client B] to go back inside her home, and she refused. She became aggressive with the officer, kicking, hitting and attempting to bite him. The officer again attempted to get [client B] to go back inside the home but she again refused...After the incident was completely diffused, the staff attempted to perform first aid to [client B]'s left eye, which had began to bruise. The staff accused of hitting [client B] was immediately suspended pending an investigation...." Further review of the report indicated the facility's nursing staff assessed client B's eye injury the next day. The report failed to indicate the facility had client B's injury immediately assessed by a nurse or doctor.</p> <p>A review of the facility's "Policy and Procedure Concerning Abuse, Neglect and Exploitation", dated 2/27/14 was conducted at the facility's administrative office on 7/30/15 at 2:30 P.M. and indicated, in part, the following: "Dungarvin believes that each individual has the right to be free from mental, emotional and physical abuse in his/her daily life....Abuse, neglect or exploitation of the individuals' (sic) served is strictly prohibited in any Dungarvin service</p>			

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	<p>delivery setting....Physical abuse is defined as any act which constitutes a violation of the assault, prostitution or criminal sexual conduct statutes including intentionally touching another person in a rude, insolent or angry manner, willful infliction of injury, unauthorized restraint/confinement resulting from physical or chemical intervention....Emotional/verbal abuse is defined as non-therapeutic conduct which produces or could reasonably be expected to produce pain or injury and is not accidental, or any repeated conduct which produces or could reasonably be expected to produce mental or emotional distress, including communicating with words or actions in a individual's presence with intent to cause fear of retaliation, fear of confinement or restraint, cause an individual to experience emotional humiliation or distress...Neglect is defined as failure to provide appropriate care, supervision, or training, failure to provide food and medical services as needed, failure to provide a safe, clean and sanitary environment and failure to provide medical supplies/safety equipment as indicated in the individual's Individual Support Plan (ISP)....The Supervisor, or Program Coordinator/Senior Director, or his/her delegate will conduct a thorough investigation of the reported incident.</p>			

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	<p>The investigation will include the following:</p> <ol style="list-style-type: none"> 1. Review of witnesses. 2. Any evidence or previous abuse or neglect. 3. All other evidence to determine the veracity and seriousness of the charge." <p>An interview with the Area Director/Qualified Intellectual Disabilities Professional (AD/QIDP) was conducted on 8/3/15 at 1:15 P.M.. The AD indicated all clients should be free of abuse and neglect. The AD indicated the facility had not developed a protocol for client C in regard to her home visits with her mother. The AD indicated client C is to be in eye sight at all times. The AD indicated client C had not been trained on sexual awareness. The AD indicated staff followed client C's BSP as written. When asked what staff should do when client C is exhibiting property destruction, the AD stated "They just watch her as long as she is not harming herself or others, she can tear the whole house up." The AD indicated the facility's nurse assessed client B the next day. The AD indicated staff did notify the nurse in regard to client B's eye injury the same day. The AD indicated he was made aware the staff started client B's behavior by telling her she would not be going on a weekend home visit. The AD</p>			

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W 0153	<p>also indicated the staff told client A to go get client B's baby doll which she is very attached to and that escalated her behaviors.</p> <p>This deficiency was cited on 6/22/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN000175587.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p>			

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Bldg. 00	<p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview for 1 of 3 allegations of abuse and neglect, the facility failed for 1 of 2 sampled clients and 1 additional client client (client B and C), to report an allegation of staff abuse and neglect immediately to the administrator.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 7/30/15 at 1:15 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports/Internal Reports (GER/IR), Daily Progress Notes and an investigation record indicated:</p> <p>-BDDS report dated 6/17/15...Date of Knowledge: 6/18/15...Date Submitted: 6/18/15 involving client C indicated: "On 6/18/15, a staff person reported that on 6/17/15 at approximately 9:00 P.M., another staff person working at the time became upset about the suggestion that the two staff take turns doing the 5 minute checks on [client C]. They stated that this staff person was sitting at the</p>	W 0153	<p>W 153 483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD) will review this Standard, and ensure:</p> <p>A. Oversight is provided to ensure Agency's abuse/neglect Policy is implemented at all times, to prevent abuse and neglect.</p> <p>B. Oversight to ensure all allegations of abuse or neglect are reported promptly and that staff demonstrate competency in Agency's Policy in regards to reporting allegations of abuse neglect.</p> <p>All current and new staff will be retrained on the following:</p> <p>i. Agency Policy and Procedure concerning abuse/neglect/exploitation of Individuals served.</p>	09/03/2015			

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	<p>table, jumped up from the table and started yelling insulting, mean and demeaning comments using profanity, regarding individuals who live in the home. This staff reported [client C] heard these things, and became upset herself and responded by saying things like, 'I don't want her to be my staff' and towards the staff, 'If you want us to respect you, you have to respect us.' After the investigation it was determined that the allegation was substantiated. Investigation revealed the staff was yelling abusive comments about individuals served and was using profanity while in the vicinity of an individual served. Furthermore it was determined that this staff refused to provide an individual served (client A) a snack when asked. These actions violated the Agency's Policy concerning abuse, neglect and exploitation of individuals served and the staff was terminated from employment." Further review of the record failed to indicate the administrator was immediately notified in regard to this incident of staff abuse and neglect.</p> <p>An interview with the Area Director/Qualified Intellectual Disabilities Professional (AD/QIDP) was conducted on 8/3/15 at 1:15 P.M.. The AD indicated the staff should have</p>		<p>ii. Refresher training on each Individual's BSP.</p> <p>C. A Director will thoroughly train all new Program Director, QDDP, and House Managers upon employment on prompt notification to the administrator of any allegation and/or suspicion of abuse/neglect .thorough and timely investigations into any allegation of abuse/neglect.</p> <p>A trained Area Director, Program Director/QDDP, Nurse, and/or Behaviorist, will review all narratives and incident reports on a regular basis to ensure any suspicion/allegation of abuse/neglect/exploitation of Individuals served are immediately reported to the administrator.</p> <p>Will be completed by: 9/2/15</p> <p>Persons Responsible: Area Director, Program Director/QDDP, Nurse, and Behaviorist</p>	

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W 0154 Bldg. 00	<p>immediately reported this incident of abuse and neglect to the administrator and further indicated they had not. The AD indicated the staff was terminated from employment because of abuse and neglect.</p> <p>This deficiency was cited on 6/22/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN000175587.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 additional client residing at the group home (client C), the facility failed to provide written evidence thorough</p>	W 0154	W 154 483.420(d)(3) STAFF TREATMENT OF CLIENTS	09/02/2015

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	<p>investigations were conducted in regard to allegations of abuse and neglect.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 7/30/15 at 1:15 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports/Internal Reports (GER/IR), Daily Progress Notes and an investigation record indicated:</p> <p>-BDDS report dated 6/17/15 involving client C indicated: "On 6/18/15, a staff person reported that on 6/17/15 at approximately 9:00 P.M., another staff person working at the time became upset about the suggestion that the two staff take turns doing the 5 minute checks on [client C]. They stated that this staff person was sitting at the table, jumped up from the table and started yelling insulting, mean and demeaning comments using profanity, regarding individuals who live in the home. This staff reported [client C] heard these things, and became upset herself and responded by saying things like, 'I don't want her to be my staff' and towards the staff, 'If you want us to respect you, you have to respect us.' After the investigation it was determined that the</p>		<p>In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD) will review this Standard, and ensure Agency's abuse/neglect Policy and Procedure is implemented at all times, including conducting thorough investigations into any allegation of abuse/neglect/exploitation, to prevent abuse and neglect of Individuals served.</p> <p>1. In regards to the 6/17/15 incident of alleged staff verbal abuse, an investigation was conducted and the allegation was substantiated. The staff person alleged to have verbally abused an individual was immediately suspended pending investigation upon notification, per protocol, and once the investigation was complete and the allegation determined substantiated, the staff person was terminated from employment per protocol. Since the allegation was substantiated based on a number of witnesses, it was unnecessary to interview all staff and all individuals served regarding the incident/allegation.</p> <p>2. Regarding the 6/22/15 incident concerning Client C's home visit and elopement, there was not a need to complete a thorough investigation. Based on the incident/evidence, it was immediately evident to Client</p>	

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	<p>allegation was substantiated.</p> <p>Investigation revealed the staff was yelling abusive comments about individuals served and was using profanity while in the vicinity of an individual served. Furthermore it was determined that this staff refused to provide an individual served (client A) a snack when asked. These actions violated the Agency's Policy concerning abuse, neglect and exploitation of individuals served and the staff was terminated from employment." Further review of the record failed to indicate all clients and all staff who worked at the group home were interviewed in regard to this allegation of abuse and neglect.</p> <p>-BDDS report dated 6/21/15 involving client C indicated: "At approximately 7:00 A.M. on 6/22/15, staff called Area Director (AD) to report that [client C]'s mother called the home to state she was unable to locate [client C]. AD instructed staff to call the police. Staff followed Protocol and notified the AD. AD talked with her mother who stated she sent [client C] to the store the previous evening of 6/21/15 and had not seen her since. However, she said she thought she knew where she was, but was not there. She said she called [client C] and [client C] said she would come home. AD then instructed staff to go to</p>		<p>C's IDT that Client C's mother did not provide the appropriate supervision during her home visit and therefore neglected the needs of Client C. It was evident that a plan was needed to ensure Client C was free from abuse/neglect on home visits with her mother. In order to implement sufficient and immediate corrective action to ensure Client C's health and safety, and to ensure Client C was free from abuse neglect, Client C's IDT immediately implemented the suspension of any home visits for Client C until a Protocol was developed, implemented, and Client C's mother trained on its implementation regarding Client C's supervision needs. At the time of survey, Client C was not going on home visits since this Protocol had not yet been fully developed, implemented, and Client C's mother had not yet been trained on her supervision. The reason for the delay was due to more pressing issues related to Client C concerning her current incarceration and determination of appropriate placement to ensure client C's health and safety and that of the community being dealt with by her IDT.</p> <p>3. Regarding the 6/29/15 incident concerning Client C's physical aggression, property destruction, and subsequent incarceration, a thorough investigation was not necessary because there was no suspicion or</p>	

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	<p>her mother's home to pick up [client C]. It was later discovered that the Police went to [client C]'s mother's home but her mother did not want to file a missing person's report. AD called [Police Department] to arrange for [Facility] staff, who was waiting for [client C] outside of her mother's house to file a missing person's report. Around this time, [client C] returned home and staff transported her to the office for an emergency IDT (Inter Disciplinary Team) meeting. [Client C] told the IDT that she slept at her 'boyfriend's house.' She stated she knew who he was and that she grew up with him, but hasn't seen him in a while. She stated she had sex with him, but that she used protection. The IDT agreed that for the time being, [client C] will not go on future home visits, but that her mother can visit her in her group home where there is staff supervision. IDT agreed that this can be revisited by the team in the future, and then short day home visits can be arranged with a staff person accompanying her on the visit, but no more overnight visits for the time being. AD will review with the mother [client C]'s supervision needs and how the ESN (Extensive Service Needs) program works. IDT will arrange for her to have sex ed classes. AD instructed staff to take [client C] to urgent care for evaluation and treatment for potential</p>		<p>allegation of abuse/neglect. Staff followed Client C's BSP and ensured the health and safety of Client C and her housemates.</p> <p>AD will ensure a thorough investigation is completed for any suspicion or allegation of abuse/neglect/exploitation of Individuals served.</p> <p>Will be completed by: 9/2/15</p> <p>Persons Responsible: Area Director, Program Director/QDDP, and Behaviorist</p>	

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	<p>exposure to STDs (Sexually Transmitted Diseases). Staff will continue to follow [client C]'s current protocol and IDT will monitor her progress." Further review of the record failed to indicate a protocol was developed in regard to client C's home visits. Further review of the record failed to indicate an investigation was conducted.</p> <p>-Follow up BDDS report dated 7/13/15 for an incident of elopement on 6/12/15 involving client C indicated: "[Client C] requires 24 hour supervision and is provided 24/7 line of sight supervision at her group home. Her BSP (Behavior Support Plan)/supervision protocol at her group home is 24/7 line of sight, with 5 minute checks during private or sleeping time to ensure she doe not elope, in order to ensure her health and safety. [Client C] and her IDT have agreed to suspend home visits to her mother's home for the time being, until there is a plan in place to ensure her health and safety on home visits....Furthermore, the AD talked with [client C]'s mother to explain the ESN program in detail, specifically in regards to [client C]'s need for 24/7 line-of-sight supervision. [Client C]'s IDT will meet with [client C]'s mother to explain the program and answer any questions she may have." Further review of the record failed to indicate an investigation was</p>			

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	<p>conducted.</p> <p>-BDDS report dated 6/29/15 involving client C indicated: "On 6/29/15 at approximately 3:30 P.M., [client C]'s roommate was having a transition meeting at the home for her discharge from the program. [Client C] was in her room taking a time to her self and she started to pour her body spray all over her pants leg. Staff followed protocol and tried to redirect [client C] to use her coping skills. [Client C] started to pick away at the dry wall inside her bedroom and continued until she had torn a big hole in the wall. She then began to exhibit more extreme property destruction and broke her desk into pieces and pulled down her window shades. She took the leg that she broke off her desk and went outside to the garage and started breaking the front and back windows out the van. Staff, Area Director (AD) and State Director (SD) followed protocol and monitored [client C] to ensure her health and safety. She continued to break all of the windows on the van and trash the sides of the van with the piece of broken wood. She took a fire extinguisher from the garage, went into the back yard and shattered the glass table. Staff locked the back doors into the home but she entered the garage again and then into the home through the</p>			
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	<p>garage. Once in the home, [client C] started to target others and AD and SD attempted a two person hold as she hit, scratched and attempted to bite AD and SD. She slid against a wall and to the ground where AD and SD released her. [Client C] was saing (sic) things like 'So you wanna touch me huh?. You wanna put you hands on me? I'm going to show yall what I can do.' She grabbed SD's leg and refused to let go. AD assisted in removing her hands from SD's leg. AD and SD gave her space. She picked up a belt she found on the table that had two metal rings at the end, wrapped it around her hand a little and started to threaten to hit staff. AD called 911 for assistance, per protocol. [Client C] returned outside in the back of the home and AD and SD instructed staff to lock all doors to home, garage and gate, in order to contain her to the back yard. [Client C] picked up various objects such as a chair, large rock, large branch and larger pieces of broken glass. She attempted to break the home windows and demanded she be let back in the home. She tried to corner and hit maintenance coordinator and SD. She then was attempting to severely harm staff, AD, SD and maintenance coordinator who were in the back yard, with a broken piece of fence with two protruding nails, large pieces of broken glass, a broken chair, a large rock and a</p>			
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	<p>large branch. She threw things at staff. All staff kept their distance while monitoring her health and safety. AD informed emergency services of all activities and police arrived. She taunted police through hole in the fence and police instructed her to drop the rock and branch and to lay on the ground or she would be tazed, while pointing tazer at her. She finally complied, threw rock and branch down. Police and AD instructed her to lay on ground as instructed to avoid being tazed. She complied and was handcuffed and arrested. SD explained to officer that no charges would be pressed due to nature of the program. Police officer said the State would be charging her with felony criminal mischief." Review of the record failed to indicate an investigation had been conducted.</p> <p>An interview with the Area Director/Qualified Intellectual Disabilities Professional (AD/QIDP) was conducted on 8/3/15 at 1:15 P.M.. The AD indicated all clients should be free of abuse and neglect. The AD indicated all staff and all clients were not interviewed in regard to the mentioned incidents.</p> <p>This deficiency was cited on 6/22/15. The facility failed to implement a systemic plan of correction to prevent</p>			

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W 0157 Bldg. 00	<p>recurrence.</p> <p>This federal tag relates to complaint #IN000175587.</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 record review and interview for 4 of 4 allegations of neglect, the facility failed for 1 of 2 sampled clients and 1 additional client (clients B and C), to take sufficient/effective corrective measures in regard to preventing/addressing staff neglect by not ensuring oversight to ensure proper supervision of clients.</p> <p>Findings include:</p> <p>1. A review of the facility's records was conducted on 7/30/15 at 1:15 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports/Internal Reports (GER/IR), Daily</p>	W 0157	<p>W 157 483.420(d)(4) STAFF TREATMENT OF CLIENTS</p> <p>In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD) will review this Standard, and ensure Agency's abuse/neglect Policy and Procedure is implemented at all times, including taking sufficient/effective corrective action to prevent recurrence.</p> <p>1. In regards to the 6/17/15 incident of alleged staff verbal abuse, an investigation was conducted and</p>	09/02/2015	

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	<p>Progress Notes and an investigation record indicated:</p> <p>-BDDS report dated 6/17/15 involving client C indicated: "On 6/18/15, a staff person reported that on 6/17/15 at approximately 9:00 P.M., another staff person working at the time became upset about the suggestion that the two staff take turns doing the 5 minute checks on [client C]. They stated that this staff person was sitting at the table, jumped up from the table and started yelling insulting, mean and demeaning comments using profanity, regarding individuals who live in the home. This staff reported [client C] heard these things, and became upset herself and responded by saying things like, 'I don't want her to be my staff' and towards the staff, 'If you want us to respect you, you have to respect us.' After the investigation it was determined that the allegation was substantiated.</p> <p>Investigation revealed the staff was yelling abusive comments about individuals served and was using profanity while in the vicinity of an individual served. Furthermore it was determined that this staff refused to provide an individual served (client A) a snack when asked. These actions violated the Agency's Policy concerning abuse, neglect and exploitation of</p>		<p>the allegation was substantiated. The staff person was terminated from employment and all other staff retrained on prompt/immediate reporting of suspected/alleged abuse/neglect.</p> <p>2. Regarding the 6/22/15 incident concerning Client C's home visit and elopement, Client C's IDT immediately suspended any home visits until a protocol was developed, implemented, and mother trained. At the time of survey, Client C was incarcerated and the IDT was determining appropriate placement to ensure her health and safety. At the time of survey, the plan had not yet been developed and implemented and therefore home visits were not occurring per the immediate effective/appropriate corrective action to prevent recurrence on home visits.</p> <p>3. Regarding the 6/29/15 incident concerning Client C's physical aggression, property destruction, and subsequent incarceration, Client C's IDT determined the home was not an appropriate placement for Client C and has recommended Client C for a more restrictive setting to ensure her health and safety. She has been referred to a SOF. Therefore, immediate/sufficient and appropriate corrective action was implemented to</p>				

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	<p>individuals served and the staff was terminated from employment." Further review of the record failed to indicate all clients and all staff who worked at the group home were interviewed in regard to this incident of abuse and neglect.</p> <p>-BDDS report dated 6/21/15 involving client C indicated: "At approximately 7:00 A.M. on 6/22/15, staff called Area Director (AD) to report that [client C]'s mother called the home to state she was unable to locate [client C]. AD instructed staff to call the police. Staff followed Protocol and notified the AD. AD talked with her mother who stated she sent [client C] to the store the previous evening of 6/21/15 and had not seen her since. However, she said she thought she knew where she was, but was not there. She said she called [client C] and [client C] said she would come home. AD then instructed staff to go to her mother's home to pick up [client C]. It was later discovered that the Police went to [client C]'s mother's home but her mother did not want to file a missing person's report. AD called [Police Department] to arrange for [Facility] staff, who was waiting for [client C] outside of her mother's house to file a missing person's report. Around this time, [client C] returned home and staff transported her to the office for an</p>		<p>prevent recurrence.</p> <p>All current and new staff will be retrained on the following:</p> <p>i. Agency Policy and Procedure concerning abuse/neglect/exploitation of Individuals served, including the immediate reporting of any suspicion or allegation of abuse/neglect/exploitation of Individuals served.</p> <p>ii. Refresher training on each Individual's BSP.</p> <p>A Director will thoroughly train all new Program Director, QDDP, and House Managers upon employment on prompt notification to the administrator of any allegation and/or suspicion of abuse/neglect .thorough and timely investigations into any allegation of abuse/neglect.</p> <p>A trained Area Director, Program Director/QDDP, Nurse, and/or Behaviorist, will review all narratives and incident reports on a regular basis to ensure any suspicion/allegation of abuse/neglect/exploitation of Individuals served are immediately reported to the administrator.</p>	

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	<p>emergency IDT (Inter Disciplinary Team) meeting. [Client C] told the IDT that she slept at her 'boyfriend's house.' She stated she knew who he was and that she grew up with him, but hasn't seen him in a while. She stated she had sex with him, but that she used protection. The IDT agreed that for the time being, [client C] will not go on future home visits, but that her mother can visit her in her group home where there is staff supervision. IDT agreed that this can be revisited by the team in the future, and then short day home visits can be arranged with a staff person accompanying her on the visit, but no more overnight visits for the time being. AD will review with the mother [client C]'s supervision needs and how the ESN (Extensive Support Needs) program works. IDT will arrange for her to have sex ed classes. AD instructed staff to take [client C] to urgent care for evaluation and treatment for potential exposure to STDs (Sexually Transmitted Diseases). Staff will continue to follow [client C]'s current protocol and IDT will monitor her progress." Further review of the record failed to indicate a protocol was developed in regard to client C's home visits.</p> <p>-Follow up BDDS report dated 7/13/15 for an incident of elopement on 6/12/15 involving client C indicated: "[Client C]</p>		<p>All staff have been retrained on each Individual's BSP and Agency Policy on abuse/neglect/exploitation,</p> <p>Will be completed by: 9/2/15</p> <p>Persons Responsible: Area Director, Program Director/QDDP, and Behaviorist</p>				

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	<p>requires 24 hour supervision and is provided 24/7 line of sight supervision at her group home. Her BSP (Behavior Support Plan)/supervision protocol at her group home is 24/7 line of sight, with 5 minute checks during private or sleeping time to ensure she does not elope, in order to ensure her health and safety. [Client C] and her IDT have agreed to suspend home visits to her mother's home for the time being, until there is a plan in place to ensure her health and safety on home visits....Furthermore, the AD talked with [client C]'s mother to explain the ESN program in detail, specifically in regards to [client C]'s need for 24/7 line-of-sight supervision. [Client C]'s IDT will meet with [client C]'s mother to explain the program and answer any questions she may have."</p> <p>-BDDS report dated 6/29/15 involving client C indicated: "On 6/29/15 at approximately 3:30 P.M., [client C]'s roommate was having a transition meeting at the home for her discharge from the program. [Client C] was in her room taking a time to her self and she started to pour her body spray all over her pants leg. Staff followed protocol and tried to redirect [client C] to use her coping skills. [Client C] started to pick away at the dry wall inside her bedroom and continued until she had torn a big</p>			

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	<p>hole in the wall. She then began to exhibit more extreme property destruction and broke her desk into pieces and pulled down her window shades. She took the leg that she broke off her desk and went outside to the garage and started breaking the front and back windows out of the van. Staff, Area Director (AD) and State Director (SD) followed protocol and monitored [client C] to ensure her health and safety. She continued to break all of the windows on the van and trash the sides of the van with the piece of broken wood. She took a fire extinguisher from the garage, went into the back yard and shattered the glass table. Staff locked the back doors into the home but she entered the garage again and then into the home through the garage. Once in the home, [client C] started to target others and AD and SD attempted a two person hold as she hit, scratched and attempted to bite AD and SD. She slid against a wall and to the ground where AD and SD released her. [Client C] was saing (sic) things like 'So you wanna touch me huh?. You wanna put you hands on me? I'm going to show yall what I can do.' She grabbed SD's leg and refused to let go. AD assisted in removing her hands from SD's leg. AD and SD gave her space. She picked up a belt she found on the table that had two metal rings at the end, wrapped it around</p>			

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	<p>her hand a little and started to threaten to hit staff. AD called 911 for assistance, per protocol. [Client C] returned outside in the back of the home and AD and SD instructed staff to lock all doors to home, garage and gate, in order to contain her to the back yard. [Client C] picked up various objects such as a chair, large rock, large branch and larger pieces of broken glass. She attempted to break the home windows and demanded she be let back in the home. She tried to corner and hit maintenance coordinator and SD. She then was attempting to severely harm staff, AD, SD and maintenance coordinator who were in the back yard, with a broken piece of fence with two protruding nails, large pieces of broken glass, a broken chair, a large rock and a large branch. She threw things at staff. All staff kept their distance while monitoring her health and safety. AD informed emergency services of all activities and police arrived. She taunted police through hole in the fence and police instructed her to drop the rock and branch and to lay on the ground or she would be tazed, while pointing tazer at her. She finally complied, threw rock and branch down. Police and AD instructed her to lay on ground as instructed to avoid being tazed. She complied and was handcuffed and arrested. SD explained to officer that no</p>			

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	<p>charges would be pressed due to nature of the program. Police officer said the State would be charging her with felony criminal mischief." Review of the record failed to indicate all staff who worked at the group home were interviewed and all clients who reside at the group home were interviewed.</p> <p>A review of client C's record was conducted on 7/31/15 at 1:50 P.M.. Review of client C's Behavioral Support Plan (BSP) dated 5/20/15 indicated:</p> <p>"BEHAVIORS TO BE DECREASED (CHALLENGING BEHAVIORS/PROBLEM BEHAVIORS: Self Injurious Behavior (SIB), Physical Aggression...Inappropriate Sexual Behavior...Stealing...Elopement:</p> <p>Self-Injurious Behavior: Using silverware to harm herself, swallowing inedible objects (screws), using her fingers to dig into a previous wound from an SIB episode. According to staff, [client C] is constantly on the lookout for objects to harm herself. This happens 4 times per month and is severe in nature. [Client C] has gone to the ER (Emergency Room) due to lacerations on her arms and neck which have led to the use of steri-strips and stitches. She has</p>			

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	<p>also had surgery to remove item(s) that she swallowed. The duration of the behavior is currently unknown.</p> <p>Physical Aggression: Towards staff and peers. [Client C] will punch people and rip their shirts. [Client C] will verbally threaten staff and peers.</p> <p>Inappropriate Sexual Behavior: Exposing herself to peer, blocking a peer from moving so she can have physical contact (for example kissing) with them, sneaking into a peer's room to engage in sexual activity with them (whether or not the peer wants to). This happens approximately 2 times per month and is severe in nature as this could lead to being charged for sexual assault.</p> <p>Stealing: Taking items that are not hers.</p> <p>Elopement: Leaving the assigned area without (1) notifying staff or responsible person of her intention to leave supervision prior to departing and/or (2) leaving the assigned area or supervision by staff after being declined permission to leave the area by staff.</p> <p>5...f. Elopement: Intervention Steps: ...If [client C] is showing signs of physical or verbal aggression of agitation and redirection is not working, staff will</p>			

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	<p>attempt to physically escort her back to the home or implement an approved DCI (crisis intervention) technique if an escort if (sic) not possible. As a last resort, staff should implement an approved DCI technique if an escort if (sic) not possible and safety becomes a concern. Agitation is described as yelling, crying, screaming, talking as if she is upset about something or someone.</p> <p>g. If staff is following [client C] and loses sight of her, they should call local law enforcement. The individual's full first name, last name, as well as middle initial, a physical description, (e.g. color and/or type of clothing last seen in, color of hair and eyes, height and weight, etc.), and the group home address should be communicated to the police....</p> <p>BEHAVIORS TO BE DECREASED (CHALLENGING BEHAVIORS/PROBLEM BEHAVIORS: Self Injurious Behavior (SIB), Physical Aggression...Elopement...Property Destruction...Refusal...Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques:</p> <p>Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques</p>				

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	<p>Less Restrictive</p> <p>Physical Redirection/Response Blocking= to change course or direction of momentum. Redirection techniques are used to take advantage of a person's momentum to redirect without holding on to the person. Response blocking is the physical intervention to stop a person's momentum during events of physical aggression without holding on to the person.</p> <p>Releasing=Gaining release from a physical hold; this may involve briefly holding to the hand or the wrist of the person.</p> <p>Walking with or accompanying/Escorting: Walking with a person to give direction, guidance, and protection from harm. Staff may use light, occasional touch or may have to use a support walk with their hand on the upper shoulder and lower arm.</p> <p>Restrictive physical interaction should only be used for the protection from harm and should be terminated as soon as the need for protection is over.</p> <p>Side Body Hug=Standing beside/slightly behind the person holding one of the arms against the person's body and your, hugging along the person's natural waist.</p>			

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	<p>This may be combined with another staff repeating this same hold on the other side of the person should a one-person hold prove to be ineffective.</p> <p>More restrictive:</p> <p>One arm Standing=Standing behind the person, holding one arm of the person in front of their body with both of your hands, hugging around the natural waistline from behind the person.</p> <p>Two Person Hold= Standing behind the person with hands in a 'c' formation at wrist with opposite arm to individual and arm closest to individual on the shoulder. Inner leg should be behind client next to their inside foot for stability. Staff on other side with the same stance, bend the person over slightly for three count then raise back up. If client drops to the floor staff is to go with them while maintaining client safety. During this procedure staff should be giving short commands to calm down, take a breath, you are safe; to the individual."</p> <p>"FOLLOW-UP:</p> <p>All of [client C]'s caregivers should be trained by his/her behavior consultant to consistently implement her behavior plan. After all staff are trained, [client</p>						

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	<p>C]'s behavior should be monitored by her behavior consultant on a weekly basis. [Client C]'s individual support team (IST) will review her BSP at least quarterly to evaluate its appropriateness." Review of the BSP failed to indicate how facility staff should intervene during property destruction to prevent client C from escalating into physical aggression.</p> <p>2. -BDDS report dated 7/28/15 involving clients A and B indicated: "On the early morning of Wednesday, July 29, [client B] was engaged in a target behavior, and was in the back yard of her home and was attempting to calm down. Her housemate came outside to ask the staff a question, and [client B] charged at her, yelling at her to go back inside. [Client B]'s housemate (client A), put her hands up to block a hit from her, and her hand hit [client B] in the left eye. As [client A] was being redirected back into the home, [client B] threw an outdoor ashtray at her. The staff spoke to [client B] and attempted to redirect her. When [client B] appeared to be calm, she went back into the house. [Client B] then locked herself up in a bathroom, and began yelling and crying that she does not like her. The staff again spoke with [client B], and she appeared to calm down. A short while later, one of [client B]'s staff left with her housemate, leaving [client</p>			

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	<p>B] at home with the second staff. [Client B] called her mom and then 911 and reported that her staff (the one present in the home with her) had hit her. The police arrived and spoke with [client B] and her staff. The police asked [client B] to go back inside her home, and she refused. She became aggressive with the officer, kicking, hitting and attempting to bite him. The officer again attempted to get [client B] to go back inside the home but she again refused...After the incident was completely diffused, the staff attempted to perform first aid to [client B]'s left eye, which had began to bruise. The staff accused of hitting [client B] was immediately suspended pending an investigation...." Further review of the report indicated the facility's nursing staff assessed client B's eye injury the next day. The report failed to indicate the facility had client B's injury immediately assessed by a nurse or doctor.</p> <p>No documentation was available for review to indicate the facility took sufficient/effective corrective action to prevent recurrence.</p> <p>An interview with the Area Director/Qualified Intellectual Disabilities Professional (AD/QIDP) was conducted on 8/3/15 at 1:15 P.M.. The AD indicated all clients should be free of</p>			

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	<p>abuse and neglect. The AD indicated the facility had not developed a protocol for client C in regard to her home visits with her mother. The AD indicated client C is to be in eye sight at all times. The AD indicated client C had not been trained on sexual awareness. The AD indicated staff followed client C's BSP as written. When asked what staff should do when client C is exhibiting property destructions, the AD stated "They just watch her as long as she is not harming herself or others, she can tear the whole house up." The AD indicated the facility's nurse assessed client B the next day. The AD indicated staff did notify the nurse in regard to client B's eye injury the same day. The AD indicated he was made aware the staff started client B's behavior by telling her she would not be going on a weekend home visit. The AD also indicated the staff told client A to go get client B's baby doll which she is very attached to and that escalated her behaviors.</p> <p>This deficiency was cited on 6/22/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN000175587.</p>			
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W 0189 Bldg. 00	<p>9-3-2(a)</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview for 1 of 2 sampled clients and 1 additional client (clients B and C), the facility failed to ensure all staff who worked with clients B and C were sufficiently trained to assure competence in regard to preventing abuse and neglect.</p> <p>Findings include:</p> <p>1. A review of the facility's records was conducted on 7/30/15 at 1:15 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports/Internal Reports (GER/IR), Daily Progress Notes and an investigation record indicated:</p>			W 0189	<p>W 189 483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD) will review this Standard, and ensure all staff are trained to assure competence in regard to preventing abuse and neglect.</p> <p>All current and new staff have been retrained on the following:</p> <p>i. Agency Policy and Procedure concerning abuse/neglect/exploitation of Individuals served.</p>		09/02/2015

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	<p>-BDDS report dated 6/17/15 involving client C indicated: on 6/18/15, a staff person reported that on 6/17/15 at approximately 9:00 P.M., another staff person working at the time became upset about the suggestion that the two staff take turns doing the 5 minute checks on [client C]. They stated that this staff person was sitting at the table, jumped up from the table and started yelling insulting, mean and demeaning comments using profanity, regarding individuals who live in the home. This staff reported [client C] heard these things, and became upset herself and responded by saying things like, 'I don't want her to be my staff' and towards the staff, 'If you want us to respect you, you have to respect us.' After the investigation it was determined that the allegation was substantiated. Investigation revealed the staff was yelling abusive comments about individuals served and was using profanity while in the vicinity of an individual served. Furthermore it was determined that this staff refused to provide an individual served (client A) a snack when asked. These actions violated the Agency's Policy concerning abuse, neglect and exploitation of individuals served and the staff was terminated from employment."</p>		<p>ii. Refresher training on each Individual's BSP.</p> <p>A. A Director will thoroughly train all new Program Director, QDDP, and House Managers upon employment on prompt notification to the administrator of any allegation and/or suspicion of abuse/neglect and on completing thorough and timely investigations into any allegation of abuse/neglect.</p> <p>A trained Area Director, Program Director/QDDP, Nurse, and/or Behaviorist, will be in the home at various and random times throughout the week, including shift changes and random overnight checks. These visits will be to ensure all Individuals' plans/protocol and all Agency policy and procedures are followed and staff demonstrate competency in regards to their job duties regarding preventing abuse/neglect and appropriately implementing all individuals' BSPs/ISPs.</p> <p>This monitoring and supervision will continue until it is evident to each Individual's IDT, the Area Director, and State Director that all Individuals are free from</p>	

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	-BDDS report dated 6/21/15 involving client C indicated: "At approximately 7:00 A.M. on 6/22/15, staff called Area Director (AD) to report that [client C]'s mother called the home to state she was unable to locate [client C]. AD instructed staff to call the police. Staff followed Protocol and notified the AD. AD talked with her mother who stated she sent [client C] to the store the previous evening of 6/21/15 and had not seen her since. However, she said she thought she knew where she was, but was not there. She said she called [client C] and [client C] said she would come home. AD then instructed staff to go to her mother's home to pick up [client C]. It was later discovered that the Police went to [client C]'s mother's home but her mother did not want to file a missing person's report. AD called [Police Department] to arrange for [Facility] staff, who was waiting for [client C] outside of her mother's house to file a missing person's report. Around this time, [client C] returned home and staff transported her to the office for an emergency IDT (Inter Disciplinary Team) meeting. [Client C] told the IDT that she slept at her 'boyfriend's house. She stated she knew who he was and that she grew up with him, but hasn't seen him in a while. She stated she had sex with him, but that she used protection. The IDT		abuse/neglect/exploitation, that all staff have demonstrated competency in all Individuals' Plans/Protocol and in Agency abuse/neglect/exploitation policy. When this has been determined, the Area Director will revise the monitoring schedule as necessary to ensure sufficient observations in order to continue the continuity and effectiveness of this plan. Will be completed by: 9/2/15 Persons Responsible: Area Director, Program Director/QDDP, Nurse, and Behaviorist	

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	<p>agreed that for the time being, [client C] will not go on future home visits, but that her mother can visit her in her group home where there is staff supervision. IDT agreed that this can be revisited by the team in the future, and then short day home visits can be arranged with a staff person accompanying her on the visit, but no more overnight visits for the time being. AD will review with the mother [client C]'s supervision needs and how the ESN program works. IDT will arrange for her to have sex ed classes. AD instructed staff to take [client C] to urgent care for evaluation and treatment for potential exposure to STDs (Sexually Transmitted Diseases). Staff will continue to follow [client C]'s current protocol and IDT will monitor her progress." Further review of the record failed to indicate a protocol was developed in regard to client C's home visits and failed to indicate client C's mother was trained in regard to her needed supervision and behaviors during home visits to her home.</p> <p>-Follow up BDDS report dated 7/13/15 for an incident of elopement on 6/12/15 involving client C indicated: "[Client C] requires 24 hour supervision and is provided 24/7 line of sight supervision at her group home. Her BSP (Behavior Support Plan)/supervision protocol at her</p>			

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	<p>group home is 24/7 line of sight, with 5 minute checks during private or sleeping time to ensure she do not elope, in order to ensure her health and safety. [Client C] and her IDT have agreed to suspend home visits to her mother's home for the time being, until there is a plan in place to ensure her health and safety on home visits....Furthermore, the AD talked with [client C]'s mother to explain the ESN program in detail, specifically in regards to [client C]'s need for 24/7 line-of-sight supervision. [Client C]'s IDT will meet with [client C]'s mother to explain the program and answer any questions she may have."</p> <p>-BDDS report dated 6/29/15 involving client C indicated: "On 6/29/15 at approximately 3:30 P.M., [client C]'s roommate was having a transition meeting at the home for her discharge from the program.]Client C] was in her room taking a time to her self and she started to pour her body spray all over her pants leg. Staff followed protocol and tried to redirect [client C] to use her coping skills. [Client C] started to pick away at the dry wall inside her bedroom and continued until she had torn a big hole in the wall. She then began to exhibit more extreme property destruction and broke her desk into pieces and pulled down her window</p>			

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	shades. She took the leg that she broke off her desk and went outside to the garage and started breaking the front and back windows out the van. Staff, Area Director (AD) and State Director (SD) followed protocol and monitored [client C] to ensure her health and safety. She continued to break all of the windows on the van and trash the sides of the van with the piece of broken wood. She took a fire extinguisher from the garage, went into the back yard and shattered the glass table. Staff locked the back doors into the home but she entered the garage again and then into the home through the garage. Once in the home, [client C] started to target others and AD and SD attempted a two person hold as she hit, scratched and attempted to bite AD and SD. She slid against a wall and to the ground where AD and SD released her. [Client C] was saing (sic) things like 'So you wanna touch me huh?. you wanna put you hands on me? I'm going to show yall what I can do,' She grabbed SD's leg and refused to let go. AD assisted in removing her hands from SD's leg. AD and SD gave her space. She picked up a belt she found on the table that had two metal rings at the end, wrapped it around her hand a little and started to threaten to hit staff. AD called 911 for assistance, per protocol. [Client C] returned outside in the back of the home and AD and SD			

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	<p>instructed staff to lock all doors to home, garage and gate, in order to contain her to the back yard. [Client C] picked up various objects such as a chair, large rock, large branch and larger pieces of broken glass. She attempted to break the home windows and demanded she be let back in the home. She tried to corner and hit maintenance coordinator and SD. She then was attempting to severely harm staff, AD, SD and maintenance coordinator who were in the back yard, with a broken piece of fence with two protruding nails, large pieces of broken glass, a broken chair, a large rock and a large branch. She threw things at staff. All staff kept their distance while monitoring her health and safety. AD informed emergency services of all activities and police arrived. She taunted police through hole in the fence and police instructed her to drop the rock and branch and to lay on the ground or she would be tazed, while pointing tazer at her. She finally complied, threw rock and branch down. Police and AD instructed her to lay on ground as instructed to avoid being tazed. She complied and was handcuffed and arrested. SD explained to officer that no charges would be pressed due to nature of the program. Police officer said the State would be charging her with felony criminal mischief."</p>			

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	<p>A review of client C's record was conducted on 7/31/15 at 1:50 P.M.. Review of client C's Behavioral Support Plan (BSP) dated 5/20/15 indicated:</p> <p>"BEHAVIORS TO BE DECREASED (CHALLENGING BEHAVIORS/PROBLEM BEHAVIORS: Self Injurious Behavior (SIB), Physical Aggression...Inappropriate Sexual Behavior...Stealing...Elopement:</p> <p>Self-Injurious Behavior: Using silverware to harm herself, swallowing inedible objects (screws), using her fingers to dig into a previous wound from an SIB episode. According to staff, [client C] is constantly on the lookout for objects to harm herself. This happens 4 times per month and is severe in nature. [Client C] has gone to the ER (Emergency Room) due to lacerations on her arms and neck which have led to the use of steri-strips and stitches. She has also had surgery to remove item(s) that she swallowed. The duration of the behavior is currently unknown.</p> <p>Physical Aggression: Towards staff and peers. [Client C] will punch people and rip their shirts. [Client C] will verbally threaten staff and peers.</p>			

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	<p>Inappropriate Sexual Behavior: Exposing herself to peer, blocking a peer from moving so she can have physical contact (for example kissing) with them, sneaking into a peer's room to engage in sexual activity with them (whether or not the peer wants to). This happens approximately 2 times per month and is severe in nature as this could lead to being charged for sexual assault.</p> <p>Stealing: Taking items that are not hers.</p> <p>Elopement: Leaving the assigned area without (1) notifying staff or responsible person of her intention to leave supervision prior to departing and/or (2) leaving the assigned area or supervision by staff after being declined permission to leave the area by staff.</p> <p>5....f. Elopement: Intervention Steps: ...If [client C] is showing signs of physical or verbal aggression of agitation and redirection is not working, staff will attempt to physically escort her back to the home or implement an approved DCI (crisis intervention) technique if an escort if (sic) not possible. As a last resort, staff should implement an approved DCI technique if an escort if (sic) not possible and safety becomes a concern. Agitation is described as yelling, crying, screaming,</p>			

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	<p>talking as if she is upset about something or someone.</p> <p>g. If staff is following [client C] and loses sight of her, they should call local law enforcement. The individual's full first name, last name, as well as middle initial, a physical description, (e.g. color and/or type of clothing last seen in, color of hair and eyes, height and weight, etc.), and the group home address should be communicated to the police....</p> <p>BEHAVIORS TO BE DECREASED (CHALLENGING BEHAVIORS/PROBLEM BEHAVIORS: Self Injurious Behavior (SIB), Physical Aggression...Elopement...Property Destruction...Refusal...Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques:</p> <p>Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques</p> <p>Less Restrictive Physical Redirection/Response Blocking= to change course or direction of momentum. Redirection techniques are used to take advantage of a person's momentum to redirect without holding on to the person. Response blocking is the physical intervention to stop a person's</p>						

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	<p>momentum during events of physical aggression without holding on to the person.</p> <p>Releasing=Gaining release from a physical hold; this may involve briefly holding to the hand or the wrist of the person.</p> <p>Walking with or accompanying/Escorting: Walking with a person to give direction, guidance, and protection from harm. Staff may use light, occasional touch or may have to use a support walk with their hand on the upper shoulder and lower arm.</p> <p>Restrictive physical interaction should only be used for the protection from harm and should be terminated as soon as the need for protection is over.</p> <p>Side Body Hug=Standing beside/slightly behind the person holding one of the arms against the person's body and your, hugging along the person's natural waist. This may be combined with another staff repeating this same hold on the other side of the person should a one-person hold prove to be ineffective.</p> <p>More restrictive:</p> <p>One arm Standing=Standing behind the</p>			

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	<p>person, holding one arm of the person in front of their body with both of your hands, hugging around the natural waistline from behind the person.</p> <p>Two Person Hold= Standing behind the person with hands in a 'c' formation at wrist with opposite arm to individual and arm closest to individual on the shoulder. Inner leg should be behind client next to their inside foot for stability. Staff on other side with the same stance, bend the person over slightly for three count then raise back up. If client drops to the floor staff is to go with them while maintaining client safety. During this procedure staff should be giving short commands to calm down, take a breath, you are safe; to the individual."</p> <p>"FOLLOW-UP:</p> <p>All of [client A]'s caregivers should be trained by his/her behavior consultant to consistently implement her behavior plan. After all staff are trained, [client A]'s behavior should be monitored by her behavior consultant on a weekly basis. [Client A]'s individual support team (IST) will review her BSP at least quarterly to evaluate its appropriateness." Review of the BSP failed to indicate how facility staff should intervene during property destruction to prevent client C</p>			

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	<p>from escalating into physical aggression.</p> <p>2. -BDDS report dated 7/28/15 involving clients A and B indicated: "On the early morning of Wednesday, July 29, [client B] was engaged in a target behavior, and was in the back yard of her home and was attempting to calm down. Her housemate came outside to ask the staff a question, and [client B] charged at her, yelling at her to go back inside. [Client B]'s housemate (client A), put her hands up to block a hit from her, and her hand hit [client B] in the left eye. As [client A] was being redirected back into the home, [client B] threw an outdoor ashtray at her. The staff spoke to [client B] and attempted to redirect her. When [client B] appeared to be calm, she went back into the house. [Client B] then locked herself up in a bathroom, and began yelling and crying that she does not like her. The staff again spoke with [client B], and she appeared to calm down. A short while later, one of [client B]'s staff left with her housemate, leaving [client B] at home with the second staff. [Client B] called her mom and then 911 and reported that her staff (the one present in the home with her) had hit her. The police arrived and spoke with [client B] and her staff. The police asked [client B] to go back inside her home, and she refused. She became aggressive with the</p>				

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	<p>officer, kicking, hitting and attempting to bite him. The officer again attempted to get [client B] to go back inside the home but she again refused...After the incident was completely diffused, the staff attempted t perform first aid to [client B]'s left eye, which had began to bruise. The staff accused of hitting [client B] was immediately suspended pending an investigation...." Further review of the report indicated the facility's nursing staff assessed client B's eye injury the next day. The report failed to indicate the facility had client B's injury immediately assessed by a nurse or doctor.</p> <p>An interview with the Area Director/Qualified Intellectual Disabilities Professional (AD/QIDP) was conducted on 8/3/15 at 1:15 P.M.. The AD indicated all staff who work at the group home with clients A and B have been trained on their BSPs. The AD indicated he was made aware the staff started client B's behavior by telling her she would not be going on a weekend home visit. The AD also indicated the staff told client A to go get client B's baby doll which she is very attached to and that escalated her behaviors.</p> <p>This deficiency was cited on 6/22/15. The facility failed to implement a systemic plan of correction to prevent</p>			

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	<p>recurrence.</p> <p>This federal tag relates to complaint #IN000175587.</p> <p>9-3-3(a)</p>			