

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G415	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/15/2013
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NAME OF PROVIDER OR SUPPLIER  EASTER SEALS ARC OF NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 8626 STANDRIDGE RUN FORT WAYNE, IN 46825
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W000000	<p>This visit was for the investigation of complaint #IN00138596.</p> <p>Complaint #IN00138596: SUBSTANTIATED, Federal and state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W186 and W194.</p> <p>Unrelated deficiency cited.</p> <p>Dates of Survey: November 6, 7, 8, 12, 13, 14 and 15, 2013.</p> <p>Surveyor: Kathy Wanner, QIDP.</p> <p>Facility number: 000929 Provider number: 15G415 AIM number: 100244520</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/25/13 by Ruth Shackelford, QIDP.</p>	W000000		
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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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W000102	<p><b>483.410 GOVERNING BODY AND MANAGEMENT</b> The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to schedule a sufficient number of staff to supervise the client needs at the group home; and failed to ensure the staff could implement behavior interventions, ensure safety and meet the clients' needs for 2 of 3 sampled clients (clients A, B, C and E).</p> <p>Findings include:</p> <p>Please refer to W122: The governing body neglected to meet the Condition of Participation: Client Protections. The governing body neglected to follow their abuse and neglect policy, failed to provide sufficient direct care staff to supervise and manage the individuals' needs for 2 of 3 sampled clients (clients A and B); and failed to ensure direct care staff were trained sufficiently to implement the behavior plan to prevent client A from his behavior of refusing to get off the van which resulted in client A being on the van for eight hours.</p> <p>Please refer to W104: The governing body failed to exercise operating direction</p>	W000102	Please see corrective action at W122 and W104	12/15/2013

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	<p>over the facility to ensure a sufficient number of trained staff were scheduled to work at the group home to implement behavior interventions, ensure safety and meet the individual needs of 2 of 3 sampled clients (clients A and client B) and 2 of 3 additional clients (clients C and E).</p> <p>This federal tag relates to complaint #IN00138596.</p> <p>9-3-1(a)</p>			

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W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview, the governing body failed to exercise operating direction over the facility to ensure a sufficient number of trained staff were scheduled to work at the group home to implement behavior interventions, ensure safety and meet the individual needs of 2 of 3 sampled clients (client A and client B) and 2 of 3 additional clients (clients C and E).</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 11/6/13 from 3:25 P.M. through 5:20 P.M. There were two staff working at the home, the Residential Manager (RM) and Direct Care Staff #1 (DCS). Client B arrived home on the city bus at 3:30 P.M. DCS #1 assisted client B with her new walker. Client B moved all the items from the storage area of her previous walker into the new one, cleaning out un-needed items. DCS #1 stayed right next to her at all times. When client B ambulated DCS #1 held on to the back of her gait belt as she walked. She had an unsteady gait and lost her balance especially at times when rising up from a seated position. DCS #1 helped to steady</p>	W000104	<p>Additional staff will be hired to maintain a 3 to 5 staffing ratio when client A is at the group home during waking hours. Person Responsible: Assistant Director Completion Date: December 15, 2013 The schedulers will be trained to appropriately respond to the staffing needs of the home Person Responsible: Assistant Director Completion Date: December 15, 2013 The schedulers will complete a checklist to indicate that all open shifts have been filled at the home. This checklist will be completed daily for one month and then weekly for two months. The assistant director will review the checklist monthly. Person Responsible: Scheduling Supervisor Completion Date: December 15, 2013 Group home staff will be trained on all client specific information including clients' dietary restrictions and dining plans. When staff persons who have not worked in the home before are scheduled, they will be trained prior to working in the home. Person Responsible: QIDP Completion Date: December</p>	12/15/2013

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	<p>her as she stood up and walked. At 4:08 P.M. the RM left to transport the other clients home from workshop. The home phone rang and DCS #1 asked this surveyor if he should leave client B's side to answer the phone. Client B stated, "They will call back." At 4:28 P.M. client E arrived home on the school bus. Client E went to her room after arriving home and remained there until dinner time. At 4:30 P.M. client A and client C arrived home on the group home van with the RM. Client D was on a home visit. The RM came in to the kitchen where client B was seated and asked DCS #1 if he would assist client A in getting off the van. DCS #1 went out to the van and client A got right off the van after DCS #1 unfastened his seatbelt. DCS #1 walked with client A into the living room and set up a tray table in front of the TV with building blocks for client A to manipulate. DCS #1 turned on a football game and sat down near client A. The RM started to make dinner. Client B remained in the kitchen with her. Client C needed assistance in getting some hygiene supplies from the supply area in the garage and asked the RM if she could get them for her. The RM asked this surveyor if surveyor would watch client B while she went to the garage to get supplies for client C.</p> <p>Facility records were reviewed on</p>		<p>15, 2013 All staff persons will be trained, in person, on the clients' behavior support plans by the QIDP or behavior consultant prior to working at the home. The staff will be required to pass a competency quiz after the training. Person Responsible: QIDP Completion Date: December 15, 2013 The QIDP will complete a checklist indicating that all staff persons have completed the client specific training for all clients prior to working at the home. This checklist will be completed weekly for 3 months. The assistant director will review the checklist monthly. Person Responsible: QIDP Completion Date: December 15, 2013 Group homestaff will be retrained on the agency on-call system so that they do not call a supervisor who is not on duty. Person Responsible: QIDP Completion Date: December 15, 2013 The group home supervisor will be trained on responding appropriately and timely to requests for assistance when she is on duty. Person Responsible: QIDP Completion Date: December 15, 2013 The QIDP will complete a monthly observation of the home to ensure that staff persons are implementing the clients' behavior support plans appropriately and following dining plans. Person Responsible: QIDP Completion Date: December 15, 2013 The QIDP will meet with</p>				

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	<p>11/7/2013 at 12:48 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time period between 10/1/13 and 11/6/13. The BDDS reports indicated the following:</p> <p>A BDDS report dated 10/21/13 for an incident on 10/20/13 at 2:00 P.M. indicated "After returning from an outing, [client A] refused to leave the van. The van was parked in the garage with the doors (garage) closed. The engine was off and the keys removed. Another client became ill (client B) and the staff had to assist her to the bathroom. There was only one staff person working. Direct Care Staff [DCS #3] contacted the supervisor. The supervisor attempted to assist over the phone and then called scheduling and requested that another staff person be sent to help. No other staff came. [Client A] was in the van for 8 hours. [Client A's] mother eventually came and got him (client A) out of the van. The Director of Quality will investigate this allegation of neglect and the incident will be reviewed by the abuse, neglect and exploitation committee. All recommendations will be followed."</p> <p>The facility's internal investigation documentation dated 11/1/13 was reviewed on 11/8/13 at 10:05 A.M. The investigation indicated "Staffing ratio at</p>		<p>the group home supervisor monthly to provide guidance and assess for additional training needs. Person Responsible: QIDP Completion Date: December 15, 2013</p>		

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	<p>time of incident 1:3 (one staff for 3 clients). Required staffing ratio at time of incident 2:5 (two staff to 5 clients). On Sunday October 20, 2013 staff [DCS #3] stated [client A] was having a good day so she asked him if he wanted to go out in the backyard with another client and herself. [DCS #3] stated that is when [client A] ran into the garage and tried to get on the van. [DCS #3] stated that she had locked the doors on the van and tried to get [client A] to go outside to the backyard by opening the back door. [DCS #3] stated [client A] tried to get into the van again this time by trying to open the doors to the lift van (sic). [DCS #3] stated after she blocked the doors with her arm and told [client A] 'no' he became upset and hit her. When she took ahold (sic) of his wrists [DCS #3] said [client A] dropped down to the ground and she let go. [DCS #3] stated that [client A] then ran and sat on top of the freezer. [DCS #3] stated this is when she went to call [Name of Residential Manager (RM)], her supervisor. [DCS #3] verbally told the investigator that she did not notice that the passenger door window was down and that is when [client A] unlocked the door from inside of the van and got inside. [DCS #3] stated that [RM] called back and said [name of staffing scheduler] couldn't find another staff to help out. but (sic) at 3or(sic) 4pm. she could come to</p>			

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	<p>help. [DCS #3] stated that she stressed to [RM] that she needed help now and not later. [DCS #3] stated, that another client [client B] was sick and vomiting so she went to help her while following [RM's] instructions to leave [client A] in the van and just check on him. [DCS #3] stated that between 2 and 3pm (sic) another house called and asked if she needed help. [DCS #3] said she told the staff on the phone that the only problem she had was with [client A] and him not wanting to get out of the van and told the staff that her supervisor had told her to give [client A] space and see if he would come out later. [DCS #3] stated that the second staff that called never came due to [DCS #3] following her supervisor's instructions and leaving [client A] in the van. [DCS #3] stated [RM] told her if [client A] did not come in then leave him out there until he is ready to come in. And (sic) to give him his medication in chocolate pudding. [DCS #3] stated [RM] told her not to force [client A] out of the van because she did not want staff to get hurt. [DCS #3] stated that when she left [client A] was still in the van. At 10pm [client A] was still in the van. According to [RM]. staff (sic) [name of DCS #4] called [RM] and told her it was getting cold and that [client A] was still in the van. RM stated that she told [DCS #4] to give [client A] a blanket and to call a male staff to help get him out</p>			

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	<p>of the van. A male staff never came and [client A's] mother sent an email to [QIDP] October 21, 2013 stating that she went to [name of group home] and got [client A] out of the van herself. [Client A's Mother] stated that [client A] still had his seatbelt on and that he had chocolate pudding all over his mouth. [Client A's Mother] stated [client A] was not allowed to eat dairy and had a bowel movement on himself." Findings: "There were discrepancies found during the course of this investigation. [DCS #5] stated that [client A] was in his room when she called to see if she needed help. [DCS #3] stated that she did not tell [DCS #5] this. [DCS #3] stated that she told [DCS #5] that [client A] was still in the van when they were talking on the phone. The original incident states that the incident took place after returning from an outing. According to [DCS #3] the incident took place after [client A] finished his morning hygiene. In [client A's Mother's] email she states that she came to the home at 10:50pm to get [client A] out of the van and after cleaning him and putting him to bed he was asleep by 10:20pm." Supplemental Material "There was no documentation found that staff [DCS #3] or [RM] were trained on a behavior support plan for [client A]. It is possible that the documentation exists. but (sic) it has not yet been found. In the client</p>			

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	<p>specific training for [client A] [Name of Director of Residential and Behavior Services (DRBS) is listed as his Behavior Consultant (BC) #1. yet (sic) [DCS #3] and [RM] did not know [client A] had a behavior plan." The RM's written statement indicated "I called scheduling and she told me that single staffing was okay because of the Gary clients and our staff shortage." The recommendations of the committee were, "That the Residential Management review the incident and make changes as appropriate to the department's systems. it is also recommended that further training to take place for [client A's] staff on his behavior plan, modifications that are needed and what works well for him."</p> <p>A review of staff training records was conducted on 11/12/13 at 8:02 A.M. The training records for DCS #3 indicated she had completed client specific training for clients A and B on 9/3/13. The training quiz regarding client A's refusals to get off the van, indicated DCS #3 had written "Ask him to help do something he likes." The training records available did not indicate DCS #3 and the RM had been trained on client A's BSP. The retraining on client A's BSP currently being done at the home observed on 11/6/13 at 4:30 P.M. indicated staff at the home were receiving a copy of client A's BSP and</p>				

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	<p>signing their name indicating they had read the BSP for client A. The training records did not indicate who was responsible for ensuring the staff were trained to implement client plans.</p> <p>1. Client A's record was reviewed on 11/6/13 at 3:45 P.M. Client A's dining plan dated 10/31/12 indicated "High fiber mechanical soft diet with additional portions, and liberal snacks. Avoid tough meat, raw vegetables, seeds, chewy bars, thick bread, nuts, and breaded products. No hot dogs, milk, soybean oil, soybean products, egg, peanuts, tomato, wheat, potatoes, and milk products." Client A's Behavior Support Plan (BSP) dated 8/16/10 written by BC #2 with a revision date 11/2/12 indicated "Description of client: [Client A] is a 25 year old...with profound intellectual disabilities. He is approximately 5' 5" / 114lbs...He has a diagnosis of seizures. He has also been diagnosed with Autism. He is allergic to dairy products." His BSP indicated the following targeted behaviors: physical aggression, resist/uncooperativeness/active resistance, AWOL (absent without leave). Recommendations for Van Removal/Tree House Removal: "[Client A] likes to help: put away stuff/carry things. If [client A] refuses to leave the van when it is in the garage at the group home. Ask [client A]</p>				

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	<p>to help you with something he likes doing. (see the list of 'What works Well for [client A].') If [client A] refuses to leave the van after you try all that works well for him let a different staff try to get him to cooperate. If he will not go inside after that use the procedure below as your last resort: 'Transport/Carry' (two person)...This procedure is to be used by two staff."</p> <p>At 4:49 P. M, the RM indicated, she and DCS #1 were both being retrained on client A's Behavior Support Plan. The RM indicated all the staff were to re-read client A's plan prior to working in the home and sign the paper attached to the plan. The RM indicated this was their training. The RM indicated they had never had any actual training by the Behavior Consultant or the QIDP.</p> <p>An interview was conducted with the RM on 11/6/13 at 4:53 P.M. The RM stated, "So far I haven't built-up a real rapport with him. I am still in my first month as manager here. [DCS #1] works very well with him. He (client A) does whatever he (DCS #1) asks him to do. I have read his BSP and his client specific training."</p> <p>An interview was conducted with DCS #1 on 11/6/13 at 4:07 P.M. DCS #1 stated, "I have heard to let him stay, wait him out. I</p>			
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	<p>heard he swung at staff, but I don't know. For the most part there are two staff. Saturdays I am here by myself from noon until 9:00 P.M. with [client B], [client C] and [client D]. The other clients go home with their family. I usually don't have any problems with him (client A). Tonight, I just unfastened his seat belt and tapped his leg a little to get him started in the right direction and he got right off the van. I have read his BSP and client specific training."</p> <p>2. Client B's record was reviewed on 11/7/13 at 3:02 P.M. Client B's record indicated "[Client B] is a high fall risk...Keep areas clear of clutter. Keep rooms well lighted. Use gait belt and when walking or transferring [client B]. Use walker when [client B] is ambulating. Staff will check to make sure gait belt is on correctly before walking or transferring...remind not to loosen gait belt."</p> <p>An interview was conducted with the Qualified Intellectual Disabilities Professional (QIDP) on 11/8/13 at 10:49 A.M. The QIDP stated, " It is not in her plan, but she is a one on one assist when she ambulates or transfers. You have to hang on to her (client B's) gait belt at all times when she is standing and walking."</p>			

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	<p>An interview was conducted with the QIDP on 11/8/13 at 10:25 A.M. The QIDP stated, "No, staff did not follow his (client A's) BSP or diet. After a few hours a transport carry technique should have been used. There was only one staff working, so staff could not do the transport carry technique. There are other things they should have tried, like giving him a bag of groceries to carry in, or his book bag." The QIDP indicated staff working on 10/20/13 had been a temp staff. The QIDP stated, "Staff had taken the power point training prior to working at the home, I don't know about training on BSP. I will need some time to look for the training sheets. She (DCS #3) has worked at the home before." The QIDP indicated it would take two staff to assist client A if the carry transport technique had to be utilized and one staff to work one on one with client B. The QIDP indicated she did not know who would be assisting the other three residents in the home. The QIDP indicated she did not know what changes had been made or were going to be made to the department systems. The QIDP indicated there was no documentation available for review to indicate what changes had been made to the Residential Department System.</p> <p>This federal tag relates to complaint #IN00138596.</p>						

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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview, for 2 of 3 sampled clients (clients A and B), the facility neglected to meet the Condition of Participation: Client Protections. The facility neglected to follow their abuse and neglect policy, failed to provide sufficient direct care staff to supervise and manage the individual needs for 2 of 3 sampled clients (clients A and B) and 2 of 3 additional clients (clients C and E); and failed to ensure direct care staff were trained sufficiently to implement the behavior plan to prevent client A from his behavior of refusing to get off the van which resulted in client A being on the van for eight hours.</p> <p>Findings include:</p> <p>Please refer to W149: The facility neglected to follow their abuse and neglect policy by neglecting to protect 1 of 3 sampled clients (client A) from his behavior of refusing to exit the van.</p> <p>Please refer to W186: The facility failed to ensure a sufficient number of trained staff were scheduled to work at the group home to implement behavior interventions, ensure safety and meet the</p>	W000122	<p>Additional staff will be hired to maintain a 3 to 5 staffing ratio when client A is at the group home during waking hours. Person Responsible: Assistant Director Completion Date: December 15, 2013 The schedulers will be trained to appropriately respond to the staffing needs of the home Person Responsible: Assistant Director Completion Date: December 15, 2013 The schedulers will complete a checklist to indicate that all open shifts have been filled at the home. This checklist will be completed daily for one month and then weekly for two months. The assistant director will review the checklist monthly. Person Responsible: Scheduling Supervisor Completion Date: December 15, 2013 Group home staff will be trained on all client specific information including clients' dietary restrictions and dining plans. When staff persons who have not worked in the home before are scheduled, they will be trained prior to working in the home. Person Responsible: QIDP Completion Date: December 15, 2013 All staff persons will be</p>	12/15/2013	

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	<p>individual needs of 2 of 3 sampled clients (clients A and client B) and 2 of 3 additional clients (clients C and E).</p> <p>Please refer to W194: The facility failed to ensure staff were trained to implement behavior interventions and follow the dining plan for 1 of 3 sampled clients (client A).</p> <p>This federal tag relates to complaint #IN00138596.</p> <p>9-3-2(a)</p>		<p>trained, in person, on the clients' behavior support plans by the QIDP or behavior consultant prior to working at the home. The staff will be required to pass a competency quiz after the training. PersonResponsible: QIDP CompletionDate: December 15, 2013 The QIDP will complete a checklist indicating that all staff persons have completed the client specific training for all clients prior to working at the home. This checklist will be completed weekly for 3 months. The assistant director will review the checklist monthly. PersonResponsible: QIDP CompletionDate: December 15, 2013 Group homestaff will be retrained on the agency on-call system so that they do not call a supervisor who is not on duty. PersonResponsible: QIDP CompletionDate: December 15, 2013 The group home supervisor will be trained on responding appropriately and timely to requests for assistance when she is on duty. PersonResponsible: QIDP CompletionDate: December 15, 2013 The QIDP will complete a monthly observation of the home to ensure that staff persons are implementing the clients' behavior support plans appropriately and following dining plans. PersonResponsible: QIDP CompletionDate: December 15, 2013 The QIDP will meet with the group home supervisor</p>		

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			monthly to provide guidance and assess for additional training needs. Person Responsible: QIDP Completion Date: December 15, 2013	

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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. Based on record review and interview, the facility neglected to follow their abuse and neglect policy by neglecting to protect 1 of 3 sampled clients (client A) from his behavior of sitting on the van which resulted in him remaining on the van for eight hours.</p> <p>Findings include:</p> <p>Facility records were reviewed on 11/7/2013 at 12:48 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time period between 10/1/13 and 11/6/13. The BDDS reports indicated the following:</p> <p>A BDDS report dated 10/21/13 for an incident on 10/20/13 at 2:00 P.M. indicated "After returning from an outing, [client A] refused to leave the van. The van was parked in the garage with the doors (garage) closed. The engine was off and the keys removed. Another client became ill (client B) and the staff had to assist her to the bathroom. There was only one staff person working. Direct Care Staff [DCS#3] contacted the supervisor. The supervisor attempted to assist over the phone and then called scheduling and</p>	W000149	<p>Additionalstaff will be hired to maintain a 3 to 5 staffing ratio when client A is at thegroup home during waking hours. PersonResponsible: Assistant DirectorCompletionDate: December 15, 2013 Theschedulers will be trained to appropriately respond to the staffing needs ofthe home PersonResponsible: Assistant DirectorCompletionDate: December 15, 2013 Theschedulers will complete a checklist to indicate that all open shifts have beenfilled at the home. This checklist will be completed daily for one month andthen weekly for two months. The assistant director will review the checklistmonthly. PersonResponsible: Scheduling SupervisorCompletionDate: December 15, 2013 Group homestaff will be trained on all client specific information including clients'dietary restrictions and dining plans. When staff persons who have not workedin the home before are scheduled, they will be trained prior to working in thehome. PersonResponsible: QIDP CompletionDate: December</p>	12/15/2013	

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	<p>requested that another staff person be sent to help. No other staff came. [Client A] was in the van for 8 hours. [Client A's] mother eventually came and got him (client A) out of the van. The Director of Quality will investigate this allegation of neglect and the incident will be reviewed by the abuse, neglect and exploitation committee. All recommendations will be followed."</p> <p>A follow-up BDDS report for the incident dated 11/5/13 indicated "The committee did not substantiate the allegation of neglect due to not meeting the definition of neglect. The committee recommended that changes be made to the department's systems and that further training take place for [client A's] staff on his behavior plan. All recommendations will be followed."</p> <p>The facility's internal investigation documentation dated 11/1/13 was reviewed on 11/8/13 at 10:05 A.M. The investigation indicated "Staffing ratio at time of incident 1:3 (one staff for 3 clients). Required staffing ratio at time of incident 2:5 (two staff to 5 clients). On Sunday October 20, 2013 staff [DCS #3] stated [client A] was having a good day so she asked him if he wanted to go out in the backyard with another client and herself. [DCS #3] stated that is when</p>		<p>15, 2013 All staff persons will be trained, in person, on the clients' behavior support plans by the QIDP or behavior consultant prior to working at the home. The staff will be required to pass a competency quiz after the training. Person Responsible: QIDP Completion Date: December 15, 2013 The QIDP will complete a checklist indicating that all staff persons have completed the client specific training for all clients prior to working at the home. This checklist will be completed weekly for 3 months. The assistant director will review the checklist monthly. Person Responsible: QIDP Completion Date: December 15, 2013 Group homestaff will be retrained on the agency on-call system so that they do not call a supervisor who is not on duty. Person Responsible: QIDP Completion Date: December 15, 2013 The group home supervisor will be trained on responding appropriately and timely to requests for assistance when she is on duty. Person Responsible: QIDP Completion Date: December 15, 2013 The QIDP will complete a monthly observation of the home to ensure that staff persons are implementing the clients' behavior support plans appropriately and following dining plans. Person Responsible: QIDP Completion Date: December 15, 2013 The QIDP will meet with</p>				

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	[client A] ran into the garage and tried to get on the van. [DCS #3] stated that she had locked the doors on the van and tried to get [client A] to go outside to the backyard by opening the back door. [DCS #3] stated [client A] tried to get into the van again this time by trying to open the doors to the lift van (sic). [DCS #3] stated after she blocked the doors with her arm and told [client A] 'no' he became upset and hit her. When she took ahold (sic) of his wrists [DCS #3] said [client A] dropped down to the ground and she let go. [DCS #3] stated that [client A] then ran and sat on top of the freezer. [DCS #3] stated this is when she went to call [Name of Residential Manager (RM)], her supervisor. [DCS #3] verbally told the investigator that she did not notice that the passenger door window was down and that is when [client A] unlocked the door from inside of the van and got inside. [DCS #3] stated that [RM] called back and said [name of staffing scheduler] couldn't find another staff to help out. but (sic) at 3or(sic) 4pm. she could come to help. [DCS #3] stated that she stressed to [RM] that she needed help now and not later. [DCS #3] stated, that another client [client B] was sick and vomiting so she went to help her while following [RM's] instructions to leave [client A] in the van and just check on him. [DCS #3] stated that between 2 and 3pm (sic) another		the group home supervisor monthly to provide guidance and assess for additional training needs. Person Responsible: QIDP Completion Date: December 15, 2013	

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	<p>house called and asked if she needed help. [DCS #3] said she told the staff on the phone that the only problem she had was with [client A] and him not wanting to get out of the van and told the staff that her supervisor had told her to give [client A] space and see if he would come out later. [DCS #3] stated that the second staff that called never came due to [DCS #3] following her supervisor's instructions and leaving [client A] in the van. [DCS #3] stated [RM] told her if [client A] did not come in then leave him out there until he is ready to come in. And (sic) to give him his medication in chocolate pudding. [DCS #3] stated [RM] told her not to force [client A] out of the van because she did not want staff to get hurt. [DCS #3] stated that when she left [client A] was still in the van. At 10pm [client A] was still in the van. According to [RM], staff (sic) [name of DCS #4] called [RM] and told her it was getting cold and that [client A] was still in the van. RM stated that she told [DCS #4] to give [client A] a blanket and to call a male staff to help get him out of the van. A male staff never came and [client A's] mother sent an email to [QIDP] October 21, 2013 stating that she went to [name of group home] and got [client A] out of the van herself. [Client A's Mother] stated that [client A] still had his seatbelt on and that he had chocolate pudding all over his mouth. [Client A's</p>			

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	<p>Mother] stated [client A] was not allowed to eat dairy and had a bowel movement on himself."</p> <p>Findings: "There were discrepancies found during the course of this investigation. [DCS #5] stated that [client A] was in his room when she called to see if she needed help. [DCS #3] stated that she did not tell [DCS #5] this. [DCS #3] stated that she told [DCS #5] that [client A] was still in the van when they were talking on the phone. The original incident states that the incident took place after returning from an outing. According to [DCS #3] the incident took place after [client A] finished his morning hygiene. In [client A's Mother's] email she states that she came to the home at 10:50pm to get [client A] out of the van and after cleaning him and putting him to bed he was asleep by 10:20pm." Supplemental Material "There was no documentation found that staff [DCS #3] or [RM] were trained on a behavior support plan for [client A]. It is possible that the documentation exists. but (sic) it has not yet been found. In the client specific training for [client A] [Name of Director of Residential and Behavior Services (DRBS) is listed as his Behavior Consultant (BC) #1. yet (sic) [DCS #3] and [RM] did not know [client A] had a behavior plan." The recommendations of</p>			

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	<p>the committee were, "That the Residential Management review the incident and make changes as appropriate to the department's systems. it is also recommended that further training to take place for [client A's] staff on his behavior plan, modifications that are needed and what works well for him."</p> <p>Client A's record was reviewed on 11/6/13 at 3:45 P.M. Client A's dining plan dated 10/31/12 indicated "High fiber mechanical soft diet with additional portions, and liberal snacks. Avoid tough meat, raw vegetables, seeds, chewy bars, thick bread, nuts, and breaded products. No hot dogs, milk, soybean oil, soybean products, egg, peanuts, tomato, wheat, potatoes, and milk products." Client A's Behavior Support Plan (BSP) dated 8/16/10 written by BC #2 with a revision date 11/2/12 indicated "Description of client: [Client A] is a 25 year old...with profound intellectual disabilities. He is approximately 5' 5" / 114lbs...He has a diagnosis of seizures. He has also been diagnosed with Autism. He is allergic to dairy products." His BSP indicated the following targeted behaviors: physical aggression, resist/uncooperativeness/active resistance, AWOL (absent without leave). Recommendations for Van Removal/Tree House Removal: "[Client A] likes to help:</p>			

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	<p>put away stuff/carry things. If [client A] refuses to leave the van when it is in the garage at the group home. Ask [client A] to help you with something he likes doing. (see the list of 'What works Well for [client A]').' If [client A] refuses to leave the van after you try all that works well for him let a different staff try to get him to cooperate. If he will not go inside after that use the procedure below as your last resort: 'Transport/Carry' (two person)...This procedure is to be used by two staff."</p> <p>An email from client A's mother to client A's Qualified Intellectual Disabilities Professional (QIDP) dated 10/21/13 at 7:54 A.M. was reviewed on 11/8/13 at 3:35 P.M. The email indicated "After talking with the staff at the home, I decided I would make the 30 minute drive to [name of city] and take care of [client A] myself. I arrived around 10:50 P.M. and found [client A] on the van. He looked exhausted and had chocolate pudding all over his mouth. I talked to him, told him he needed to be in bed then tried to get him up. I then realized he had his seatbelt on. Once I took it off, he got right up with assistance. I then discovered that he had pooped himself. I told him that we needed to go get cleaned up in the bathroom. He went right in. He was such a mess that I gave him a shower. He got</p>			

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	<p>dressed and went right to bedroom and got in bed. I put a movie in, told him I loved him and he needed to go to sleep. He was asleep by 10:20 P.M. This was all done in 30 minutes with no resistance or aggression. I think help finally came while I was showering [client A]. It was obvious to me that the staff is not trained on how to communicate to [client A]. It is not difficult, but you have to be willing and not afraid. When he is irritable, there is a reason, look for it. Also I thought there were to be two staff when there is (sic) five clients...I thought the staff would get some help or I would have come earlier. If I have to come in and train staff, I will do that for [client A's] sake. This cannot continue. I have not seen [client A] this thin. It about killed me to see him in the condition he was when I got there. I know the chocolate pudding was a big mistake and he suffered because of it...I hope something will be done to not let his being in the van for hours to continue. Also you do not need to use force or carry him in. There are other ways that work."</p> <p>The facility Standard Operating Procedures / Abuse and Neglect Policy revision date 5/07 was reviewed on 11/6/13 at 6:29 P.M. The policy indicated "Client safety is of utmost importance to the staff of Easter Seals Arc. To promote</p>			

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	<p>the health, safety, and security of people who live in Easter Seals ARC Group Homes. Abuse and neglect of clients will not be tolerated...A.)...Abuse, neglect, exploitation, and mistreatment are expressly forbidden...Suspected instances of neglect, abuse, exploitation, client mistreatment or any infractions of this policy by staff must be reported to the Supervisor, Manager, or President immediately. This supervisor will then report the alleged violation(s) to the client's legal representative if applicable and to any other person according to BDDS regulations when applicable. Employees must report suspected or observed instances of neglect, abuse, or exploitation....To ensure appropriate reporting, follow-up, and monitoring of incidents and injuries... 8. For any incident with the potential for having been caused by abuse, neglect, or exploitation, the Quality Assurance Officer will investigate the circumstances surrounding the incident including interviewing clients and staff...10. The QMRP (Qualified Mental Retardation Professional) will submit a BDDS follow-up report 7 (seven) calendar days or 5 (five) business days after the incident. Copies will be given to the local BDDS office...and the President of Easter Seals ARC."</p>			

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	<p>An interview was conducted with the RM on 11/6/13 at 4:53 P.M. The RM stated, "So far I haven't built-up a real rapport with him. I am still in my first month as manager here. [DCS #1] works very well with him. He (client A) does whatever he (DCS #1) asks him to do. I have read his BSP and his client specific training."</p> <p>An interview was conducted with DCS #1 on 11/6/13 at 4:07 P.M. DCS #1 stated, "I have heard to let him stay, wait him out. I heard he swung at staff, but I don't know. For the most part there are two staff. Saturdays I am here by myself from noon until 9:00 P.M. with [client B], [client C] and [client D]. The other clients go home with their family. I usually don't have any problems with him (client A). Tonight, I just unfastened his seat belt and tapped his leg a little to get him started in the right direction and he got right off the van."</p> <p>An interview was conducted with the QIDP on 11/8/13 at 10:25 A.M. The QIDP stated, "No, staff did not follow his (client A's) BSP or diet. After a few hours a transport carry technique should have been used. There was only one staff working, so staff could not do the transport carry technique. There are other things they should have tried, like giving him a bag of groceries to carry in, or his</p>			

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	<p>book bag." The QIDP indicated staff working on 10/20/13 had been a temp staff. The QIDP stated, "Staff had taken the power point training prior to working at the home, I don't know about training on BSP. I will need some time to look for the training sheets. She has worked at the home before." The QIDP stated, "There are paper copies of the BSPs and client specific plans at the home as well as on Therap (electronic files). The QIDP stated, "Mom was really upset at the time due to the length of time he was on the van." The QIDP indicated it is policy for staff to follow a client's plan. The QIDP indicated there was no documentation available for review to indicate what changes had been made to the Residential Department System.</p> <p>This federal tag relates to complaint #IN00138596.</p> <p>9-3-2(a)</p>			

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W000186	<p>483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, record review and interview, the facility failed to provide sufficient direct care staff to manage and supervise clients in accordance with their individual needs for 2 of 3 sampled clients (clients A and B) and for 2 of 3 additional clients (clients C and E).</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 11/6/13 from 3:25 P.M. through 5:20 P.M. There were two staff working at the home, the Residential Manager (RM) and Direct Care Staff #1 (DCS). Client B arrived home on the city bus at 3:30 P.M. DCS #1 assisted client B with her new walker. Client B moved all the items from the storage area of her previous walker into the new one, cleaning out un-needed items. DCS #1 stayed right next to her at all times. When client B ambulated DCS #1 held on to the back of her gait belt as she walked. She had an unsteady gait and lost her balance</p>	W000186	<p>Additionalstaff will be hired to maintain a 3 to 5 staffing ratio when client A is at thegroup home during waking hours. PersonResponsible: Assistant DirectorCompletionDate: December 15, 2013 Theschedulers will be trained to appropriately respond to the staffing needs ofthe home PersonResponsible: Assistant DirectorCompletionDate: December 15, 2013 Theschedulers will complete a checklist to indicate that all open shifts have beenfilled at the home. This checklist will be completed daily for one month andthen weekly for two months. The assistant director will review the checklistmonthly. PersonRespons ible: Scheduling SupervisorCompletionDate: December 15, 2013 Group homestaff will be trained on all client specific information including clients'dietary restrictions and dining plans.</p>	12/15/2013			

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	<p>especially at times when rising up from a seated position. DCS #1 helped to steady her as she stood up and walked. At 4:08 P.M. the RM left to transport the other clients home from workshop. The home phone rang and DCS #1 asked this surveyor if he should leave client B's side to answer the phone. Client B stated, "They will call back." At 4:28 P.M. client E arrived home on the school bus. Client E went to her room after arriving home and remained there until dinner time. At 4:30 P.M. client A and client C arrived home on the group home van with the RM. Client D was on a home visit. The RM came in to the kitchen where client B was seated and asked DCS #1 if he would assist client A in getting off the van. DCS #1 went out to the van and client A got right off the van after DCS #1 unfastened his seatbelt. DCS #1 walked with client A into the living room and set up a tray table in front of the TV with building blocks for client A to manipulate. DCS #1 turned on a football game and sat down near client A. The RM started to make dinner. Client B remained in the kitchen with her. Client C needed assistance in getting some hygiene supplies from the supply area in the garage and asked the RM if she could get them for her. The RM asked this surveyor if surveyor would watch client B while she went to the garage to get supplies for client C.</p>		<p>When staff persons who have not worked in the home before are scheduled, they will be trained prior to working in the home. Person Responsible: QIDP Completion Date: December 15, 2013 All staff persons will be trained, in person, on the clients' behavior support plans by the QIDP or behavior consultant prior to working at the home. The staff will be required to pass a competency quiz after the training. Person Responsible: QIDP Completion Date: December 15, 2013 The QIDP will complete a checklist indicating that all staff persons have completed the client specific training for all clients prior to working at the home. This checklist will be completed weekly for 3 months. The assistant director will review the checklist monthly. Person Responsible: QIDP Completion Date: December 15, 2013 Group home staff will be retrained on the agency on-call system so that they do not call a supervisor who is not on duty. Person Responsible: QIDP Completion Date: December 15, 2013 The group home supervisor will be trained on responding appropriately and timely to requests for assistance when she is on duty Person Responsible: QIDP Completion Date: December 15, 2013 The QIDP will complete a monthly observation of the home to ensure that staff persons</p>		

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	<p>Facility records were reviewed on 11/7/2013 at 12:48 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time period between 10/1/13 and 11/6/13. The BDDS reports indicated the following:</p> <p>A BDDS report dated 10/21/13 for an incident on 10/20/13 at 2:00 P.M. indicated "After returning from an outing, [client A] refused to leave the van. The van was parked in the garage with the doors (garage) closed. The engine was off and the keys removed. Another client became ill (client B) and the staff had to assist her to the bathroom. There was only one staff person working. Direct Care Staff [DCS #3] contacted the supervisor. The supervisor attempted to assist over the phone and then called scheduling and requested that another staff person be sent to help. No other staff came. [Client A] was in the van for 8 hours. [Client A's] mother eventually came and got him (client A) out of the van. The Director of Quality will investigate this allegation of neglect and the incident will be reviewed by the abuse, neglect and exploitation committee. All recommendations will be followed."</p> <p>The facility's internal investigation documentation dated 11/1/13 was</p>		<p>areimplementing the clients' behavior support plans appropriately and followingdining plans PersonResponsible: QIDPCompletionDate: December 15, 2013 The QIDP willmeet with the group home supervisor monthly to provide guidance and assess foradditional training needs. Person Responsible:QIDPCompletionDate: December 15, 2013</p>		

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	<p>reviewed on 11/8/13 at 10:05 A.M. The investigation indicated "Staffing ratio at time of incident 1:3 (one staff for 3 clients). Required staffing ratio at time of incident 2:5 (two staff to 5 clients). On Sunday October 20, 2013 staff [DCS #3] stated [client A] was having a good day so she asked him if he wanted to go out in the backyard with another client and herself. [DCS #3] stated that is when [client A] ran into the garage and tried to get on the van. [DCS #3] stated that she had locked the doors on the van and tried to get [client A] to go outside to the backyard by opening the back door. [DCS #3] stated [client A] tried to get into the van again this time by trying to open the doors to the lift van (sic). [DCS #3] stated after she blocked the doors with her arm and told [client A] 'no' he became upset and hit her. When she took ahold (sic) of his wrists [DCS #3] said [client A] dropped down to the ground and she let go. [DCS #3] stated that [client A] then ran and sat on top of the freezer. [DCS #3] stated this is when she went to call [Name of Residential Manager (RM)], her supervisor. [DCS #3] verbally told the investigator that she did not notice that the passenger door window was down and that is when [client A] unlocked the door from inside of the van and got inside. [DCS #3] stated that [RM] called back and said [name of staffing scheduler]</p>			

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	<p>couldn't find another staff to help out. but (sic) at 3or(sic) 4pm. she could come to help. [DCS #3] stated that she stressed to [RM] that she needed help now and not later. [DCS #3] stated, that another client [client B] was sick and vomiting so she went to help her while following [RM's] instructions to leave [client A] in the van and just check on him. [DCS #3] stated that between 2 and 3pm (sic) another house called and asked if she needed help. [DCS #3] said she told the staff on the phone that the only problem she had was with [client A] and him not wanting to get out of the van and told the staff that her supervisor had told her to give [client A] space and see if he would come out later. [DCS #3] stated that the second staff that called never came due to [DCS #3] following her supervisor's instructions and leaving [client A] in the van. [DCS #3] stated [RM] told her if [client A] did not come in then leave him out there until he is ready to come in. And (sic) to give him his medication in chocolate pudding. [DCS #3] stated [RM] told her not to force [client A] out of the van because she did not want staff to get hurt. [DCS #3] stated that when she left [client A] was still in the van. At 10pm [client A] was still in the van. According to [RM], staff (sic) [name of DCS #4] called [RM] and told her it was getting cold and that [client A] was still in the van. RM stated that she</p>			

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	<p>told [DCS #4] to give [client A] a blanket and to call a male staff to help get him out of the van. A male staff never came and [client A's] mother sent an email to [QIDP] October 21, 2013 stating that she went to [name of group home] and got [client A] out of the van herself. [Client A's Mother] stated that [client A] still had his seatbelt on and that he had chocolate pudding all over his mouth. [Client A's Mother] stated [client A] was not allowed to eat dairy and had a bowel movement on himself."</p> <p>Findings: "There were discrepancies found during the course of this investigation. [DCS #5] stated that [client A] was in his room when she called to see if she needed help. [DCS #3] stated that she did not tell [DCS #5] this. [DCS #3] stated that she told [DCS #5] that [client A] was still in the van when they were talking on the phone. The original incident states that the incident took place after returning from an outing. According to [DCS #3] the incident took place after [client A] finished his morning hygiene. In [client A's Mother's] email she states that she came to the home at 10:50pm to get [client A] out of the van and after cleaning him and putting him to bed he was asleep by 10:20pm." Supplemental Material "There was no documentation found that staff [DCS #3] or [RM] were</p>			

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	<p>trained on a behavior support plan for [client A]. It is possible that the documentation exists. but (sic) it has not yet been found. In the client specific training for [client A] [Name of Director of Residential and Behavior Services (DRBS) is listed as his Behavior Consultant (BC) #1. yet (sic) [DCS #3] and [RM] did not know [client A] had a behavior plan." The RM's written statement indicated "I called scheduling and she told me that single staffing was okay because of the [city] clients and our staff shortage." The recommendations of the committee were, "That the Residential Management review the incident and make changes as appropriate to the department's systems. it is also recommended that further training to take place for [client A's] staff on his behavior plan, modifications that are needed and what works well for him."</p> <p>1. Client A's record was reviewed on 11/6/13 at 3:45 P.M. Client A's dining plan dated 10/31/12 indicated "High fiber mechanical soft diet with additional portions, and liberal snacks. Avoid tough meat, raw vegetables, seeds, chewy bars, thick bread, nuts, and breaded products. No hot dogs, milk, soybean oil, soybean products, egg, peanuts, tomato, wheat, potatoes, and milk products." Client A's Behavior Support Plan (BSP) dated</p>			

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	<p>8/16/10 written by BC #2 with a revision date 11/2/12 indicated "Description of client: [Client A] is a 25 year old...with profound intellectual disabilities. He is approximately 5' 5" / 114lbs...He has a diagnosis of seizures. He has also been diagnosed with Autism. He is allergic to dairy products." His BSP indicated the following targeted behaviors: physical aggression, resist/uncooperativeness/active resistance, AWOL (absent without leave). Recommendations for Van Removal/Tree House Removal: "[Client A] likes to help: put away stuff/carry things. If [client A] refuses to leave the van when it is in the garage at the group home. Ask [client A] to help you with something he likes doing. (see the list of 'What works Well for [client A]).' If [client A] refuses to leave the van after you try all that works well for him let a different staff try to get him to cooperate. If he will not go inside after that use the procedure below as your last resort: 'Transport/Carry' (two person)...This procedure is to be used by two staff."</p> <p>At 4:49 P. M, the RM indicated, she and DCS #1 were both being retrained on client A's Behavior Support Plan. The RM indicated all the staff were to re-read client A's plan prior to working in the home and sign the paper attached to the</p>			

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	<p>plan. The RM indicated this was their training. The RM indicated they had never had any actual training by the Behavior Consultant or the QIDP.</p> <p>An interview was conducted with the RM on 11/6/13 at 4:53 P.M. The RM stated, "So far I haven't built-up a real rapport with him. I am still in my first month as manager here. [DCS #1] works very well with him. He (client A) does whatever he (DCS #1) asks him to do. I have read his BSP and his client specific training."</p> <p>An interview was conducted with DCS #1 on 11/6/13 at 4:07 P.M. DCS #1 stated, "I have heard to let him stay, wait him out. I heard he swung at staff, but I don't know. For the most part there are two staff. Saturdays I am here by myself from noon until 9:00 P.M. with [client B], [client C] and [client D]. The other clients go home with their family. I usually don't have any problems with him (client A). Tonight, I just unfastened his seat belt and tapped his leg a little to get him started in the right direction and he got right off the van. I have read his BSP and client specific training."</p> <p>2. Client B's record was reviewed on 11/7/13 at 3:02 P.M. Client B's record indicated "[Client B] is a high fall risk...Keep areas clear of clutter. Keep</p>				

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	<p>rooms well lighted. Use gait belt and when walking or transferring [client B]. Use walker when [client B] is ambulating. Staff will check to make sure gait belt is on correctly before walking or transferring...remind not to loosen gait belt."</p> <p>An interview was conducted with the Qualified Intellectual Disabilities Professional (QIDP) on 11/8/13 at 10:49 A.M. The QIDP stated, "It is not in her plan, but she is a one on one assist when she ambulates or transfers. You have to hang on to her (client B's) gait belt at all times when she is standing and walking."</p> <p>An interview was conducted with the QIDP on 11/8/13 at 10:25 A.M. The QIDP stated, "No, staff did not follow his (client A's) BSP or diet. After a few hours a transport carry technique should have been used. There was only one staff working, so staff could not do the transport carry technique. There are other things they should have tried, like giving him a bag of groceries to carry in, or his book bag." The QIDP indicated staff working on 10/20/13 had been a temp staff. The QIDP stated, "Staff had taken the power point training prior to working at the home, I don't know about training on BSP. I will need some time to look for the training sheets. She (DCS #3) has</p>			

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	<p>worked at the home before." The QIDP indicated it would take two staff to assist client A if the carry transport technique had to be utilized and one staff to work one on one with client B. The QIDP indicated she did not know who would be assisting the other three residents in the home. The QIDP indicated she did not know what changes had been made or were going to be made to the department systems. The QIDP indicated there was no documentation available for review to indicate what changes had been made to the Residential Department System.</p> <p>This federal tag relates to complaint #IN00138596.</p> <p>9-3-3(a)</p>				

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W000194	<p>483.430(e)(4) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. Based on observation, record review and interview, the facility failed to assure direct care staff were trained and competent to implement the individual program plans for 2 of 3 sampled clients (clients A and B).</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 11/6/13 from 3:25 P.M. through 5:20 P.M. There were two staff working at the home, the Residential Manager (RM) and Direct Care Staff #1 (DCS). Client B arrived home on the city bus at 3:30 P.M. DCS #1 assisted client B with her new walker. Client B moved all the items from the storage area of her previous walker into the new one, cleaning out un-needed items. DCS #1 stayed right next to her at all times. When client B ambulated DCS #1 held on to the back of her gait belt as she walked. She had an unsteady gait and lost her balance especially at times when rising up from a seated position. DCS #1 helped to steady her as she stood up and walked. At 4:08 P.M. the RM left to transport the other clients home from workshop. The home</p>	W000194	<p>Additionalstaff will be hired to maintain a 3 to 5 staffing ratio when client A is at thegroup home during waking hours. PersonResponsible: Assistant DirectorCompletionDate: December 15, 2013 Theschedulers will be trained to appropriately respond to the staffing needs ofthe home PersonResponsible: Assistant DirectorCompletionDate: December 15, 2013 Theschedulers will complete a checklist to indicate that all open shifts have beenfilled at the home. This checklist will be completed daily for one month andthen weekly for two months. The assistant director will review the checklistmonthly. PersonResponsible: Scheduling SupervisorCompletionDate: December 15, 2013 Group homestaff will be trained on all client specific information including clients'dietary restrictions and dining plans. When staff persons who have not workedin the home before are scheduled, they will be trained prior to working in thehome. PersonResponsible:</p>	12/15/2013			

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	<p>phone rang and DCS #1 asked this surveyor if he should leave client B's side to answer the phone. Client B stated, "They will call back." At 4:28 P.M. client E arrived home on the school bus. Client E went to her room after arriving home and remained there until dinner time. At 4:30 P.M. client A and client C arrived home on the group home van with the RM. Client D was on a home visit. The RM came in to the kitchen where client B was seated and asked DCS #1 if he would assist client A in getting off the van. DCS #1 went out to the van and client A got right off the van after DCS #1 unfastened his seatbelt. DCS #1 walked with client A into the living room and set up a tray table in front of the TV with building blocks for client A to manipulate. DCS #1 turned on a football game and sat down near client A. The RM started to make dinner. Client B remained in the kitchen with her. Client C needed assistance in getting some hygiene supplies from the supply area in the garage and asked the RM if she could get them for her. The RM asked this surveyor if surveyor would watch client B while she went to the garage to get supplies for client C.</p> <p>Facility records were reviewed on 11/7/2013 at 12:48 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time</p>		<p>QIDPCompletionDate: December 15, 2013 All staff persons will be trained, in person, on the clients' behavior support plans by the QIDP or behavior consultant prior to working at the home. The staff will be required to pass a competency quiz after the training. PersonResponsible: QIDPCompletionDate: December 15, 2013 The QIDP will complete a checklist indicating that all staff persons have completed the client specific training for all clients prior to working at the home. This checklist will be completed weekly for 3 months. The assistant director will review the checklist monthly. PersonResponsible: QIDP CompletionDate: December 15, 2013 Group homestaff will be retrained on the agency on-call system so that they do not call a supervisor who is not on duty. PersonResponsible: QIDPCompletionDate: December 15, 2013 The group home supervisor will be trained on responding appropriately and timely to requests for assistance when she is on duty. PersonResponsible: QIDPCompletionDate: December 15, 2013 The QIDP will complete a monthly observation of the home to ensure that staff persons are implementing the clients' behavior support plans appropriately and following dining plans. PersonResponsible: QIDPCompletionDate: December</p>		

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	<p>period between 10/1/13 and 11/6/13. The BDDS reports indicated the following:</p> <p>A BDDS report dated 10/21/13 for an incident on 10/20/13 at 2:00 P.M. indicated "After returning from an outing, [client A] refused to leave the van. The van was parked in the garage with the doors (garage) closed. The engine was off and the keys removed. Another client became ill (client B) and the staff had to assist her to the bathroom. There was only one staff person working. Direct Care Staff [DCS #3] contacted the supervisor. The supervisor attempted to assist over the phone and then called scheduling and requested that another staff person be sent to help. No other staff came. [Client A] was in the van for 8 hours. [Client A's] mother eventually came and got him (client A) out of the van. The Director of Quality will investigate this allegation of neglect and the incident will be reviewed by the abuse, neglect and exploitation committee. All recommendations will be followed."</p> <p>The facility's internal investigation documentation dated 11/1/13 was reviewed on 11/8/13 at 10:05 A.M. The investigation indicated "Staffing ratio at time of incident 1:3 (one staff for 3 clients). Required staffing ratio at time of incident 2:5 (two staff to 5 clients). On</p>		<p>15, 2013 The QIDP will meet with the group home supervisor monthly to provide guidance and assess for additional training needs. Person Responsible: QIDP Completion Date: December 15, 2013</p>				

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	<p>Sunday October 20, 2013 staff [DCS #3] stated [client A] was having a good day so she asked him if he wanted to go out in the backyard with another client and herself. [DCS #3] stated that is when [client A] ran into the garage and tried to get on the van. [DCS #3] stated that she had locked the doors on the van and tried to get [client A] to go outside to the backyard by opening the back door. [DCS #3] stated [client A] tried to get into the van again this time by trying to open the doors to the lift van (sic). [DCS #3] stated after she blocked the doors with her arm and told [client A] 'no' he became upset and hit her. When she took ahold (sic) of his wrists [DCS #3] said [client A] dropped down to the ground and she let go. [DCS #3] stated that [client A] then ran and sat on top of the freezer. [DCS #3] stated this is when she went to call [Name of Residential Manager (RM)], her supervisor. [DCS #3] verbally told the investigator that she did not notice that the passenger door window was down and that is when [client A] unlocked the door from inside of the van and got inside. [DCS #3] stated that [RM] called back and said [name of staffing scheduler] couldn't find another staff to help out. but (sic) at 3or(sic) 4pm. she could come to help. [DCS #3] stated that she stressed to [RM] that she needed help now and not later. [DCS #3] stated, that another client</p>			

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	[client B] was sick and vomiting so she went to help her while following [RM's] instructions to leave [client A] in the van and just check on him. [DCS #3] stated that between 2 and 3pm (sic) another house called and asked if she needed help. [DCS #3] said she told the staff on the phone that the only problem she had was with [client A] and him not wanting to get out of the van and told the staff that her supervisor had told her to give [client A] space and see if he would come out later. [DCS #3] stated that the second staff that called never came due to [DCS #3] following her supervisor's instructions and leaving [client A] in the van. [DCS #3] stated [RM] told her if [client A] did not come in then leave him out there until he is ready to come in. And (sic) to give him his medication in chocolate pudding. [DCS #3] stated [RM] told her not to force [client A] out of the van because she did not want staff to get hurt. [DCS #3] stated that when she left [client A] was still in the van. At 10pm [client A] was still in the van. According to [RM], staff (sic) [name of DCS #4] called [RM] and told her it was getting cold and that [client A] was still in the van. RM stated that she told [DCS #4] to give [client A] a blanket and to call a male staff to help get him out of the van. A male staff never came and [client A's] mother sent an email to [QIDP] October 21, 2013 stating that she			

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	<p>went to [name of group home] and got [client A] out of the van herself. [Client A's Mother] stated that [client A] still had his seatbelt on and that he had chocolate pudding all over his mouth. [Client A's Mother] stated [client A] was not allowed to eat dairy and had a bowel movement on himself."</p> <p>Findings: "There were discrepancies found during the course of this investigation. [DCS #5] stated that [client A] was in his room when she called to see if she needed help. [DCS #3] stated that she did not tell [DCS #5] this. [DCS #3] stated that she told [DCS #5] that [client A] was still in the van when they were talking on the phone. The original incident states that the incident took place after returning from an outing. According to [DCS #3] the incident took place after [client A] finished his morning hygiene. In [client A's Mother's] email she states that she came to the home at 10:50pm to get [client A] out of the van and after cleaning him and putting him to bed he was asleep by 10:20pm." Supplemental Material "There was no documentation found that staff [DCS #3] or [RM] were trained on a behavior support plan for [client A]. It is possible that the documentation exists. but (sic) it has not yet been found. In the client specific training for [client A] [Name of Director</p>			

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	<p>of Residential and Behavior Services (DRBS) is listed as his Behavior Consultant (BC) #1. yet (sic) [DCS #3] and [RM] did not know [client A] had a behavior plan." The RM's written statement indicated "I called scheduling and she told me that single staffing was okay because of the [city] clients and our staff shortage." The recommendations of the committee were, "That the Residential Management review the incident and make changes as appropriate to the department's systems. It is also recommended that further training to take place for [client A's] staff on his behavior plan, modifications that are needed and what works well for him."</p> <p>An email from client A's mother to client A's Qualified Intellectual Disabilities Professional (QIDP) dated 10/21/13 at 7:54 A.M. was reviewed on 11/8/13 at 3:35 P.M. The email indicated "After talking with the staff at the home, I decided I would make the 30 minute drive to Ft. Wayne and take care of [client A] myself. I arrived around 10:50 P.M. and found [client A] on the van. He looked exhausted and had chocolate pudding all over his mouth. I talked to him, told him he needed to be in bed then tried to get him up. I then realized he had his seatbelt on. Once I took it off, he got right up with assistance. I then discovered that he had</p>			

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	<p>pooped himself. I told him that we needed to go get cleaned up in the bathroom. he went right in. He was such a mess that I gave him a shower. he got dressed and went right to bedroom and got in bed. I put a movie in, told him I loved him and he needed to go to sleep. He was asleep by 10:20 P.M. This was all done in 30 minutes with no resistance or aggression. I think help finally came while I was showering [client A]. It was obvious to me that the staff is not trained on how to communicate to [client A]. It is not difficult, but you have to be willing and not afraid. When he is irritable, there is a reason, look for it. Also I thought there were to be two staff when there is (sic) five clients...I thought the staff would get some help or I would have come earlier. If I have to come in and train staff, I will do that for [client A's] sake. This cannot continue. I have not seen [client A] this thin. It about killed me to see him in the condition he was when I got there. I know the chocolate pudding was a big mistake and he suffered because of it...I hope something will be done to not let his being in the van for hours to continue. Also you do not need to use force or carry him in. There are other ways that work."</p> <p>1. Client A's record was reviewed on 11/6/13 at 3:45 P.M. Client A's dining plan dated 10/31/12 indicated "High fiber</p>			

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	<p>mechanical soft diet with additional portions, and liberal snacks. Avoid tough meat, raw vegetables, seeds, chewy bars, thick bread, nuts, and breaded products. No hot dogs, milk, soybean oil, soybean products, egg, peanuts, tomato, wheat, potatoes, and milk products." Client A's Behavior Support Plan (BSP) dated 8/16/10 written by BC #2 with a revision date 11/2/12 indicated "Description of client: [Client A] is a 25 year old...with profound intellectual disabilities. He is approximately 5' 5" / 114lbs...He has a diagnosis of seizures. He has also been diagnosed with Autism. He is allergic to dairy products." His BSP indicated the following targeted behaviors: physical aggression, resist/uncooperativeness/active resistance, AWOL (absent without leave). Recommendations for Van Removal/Tree House Removal: "[Client A] likes to help: put away stuff/carry things. If [client A] refuses to leave the van when it is in the garage at the group home. Ask [client A] to help you with something he likes doing. (see the list of 'What works Well for [client A]).' If [client A] refuses to leave the van after you try all that works well for him let a different staff try to get him to cooperate. If he will not go inside after that use the procedure below as your last resort: 'Transport/Carry' (two person)...This procedure is to be used by</p>			

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	<p>two staff."</p> <p>At 4:49 P. M, the RM indicated, she and DCS #1 were both being retrained on client A's Behavior Support Plan. The RM indicated all the staff were to re-read client A's plan prior to working in the home and sign the paper attached to the plan. The RM indicated this was their training. The RM indicated they had never had any actual training by the Behavior Consultant or the QIDP.</p> <p>An interview was conducted with the RM on 11/6/13 at 4:53 P.M. The RM stated, "So far I haven't built-up a real rapport with him. I am still in my first month as manager here. [DCS #1] works very well with him. He (client A) does whatever he (DCS #1) asks him to do. I have read his BSP and his client specific training."</p> <p>An interview was conducted with DCS #1 on 11/6/13 at 4:07 P.M. DCS #1 stated, "I have heard to let him stay, wait him out. I heard he swung at staff, but I don't know. For the most part there are two staff. Saturdays I am here by myself from noon until 9:00 P.M. with [client B], [client C] and [client D]. The other clients go home with their family. I usually don't have any problems with him (client A). Tonight, I just unfastened his seat belt and tapped his leg a little to get him started in the</p>			

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NAME OF PROVIDER OR SUPPLIER  EASTER SEALS ARC OF NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 8626 STANDRIDGE RUN FORT WAYNE, IN 46825
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	<p>right direction and he got right off the van. I have read his BSP and client specific training."</p> <p>A review of staff training record was conducted on 11/12/13 at 8:02 A.M. The training records for DCS #3 indicated she had completed client specific training for clients A and B on 9/3/13. The training quiz regarding client A's refusals to get off the van, indicated DCS #3 had written "Ask him to help do something he likes." The training records available did not indicate DCS #3 and the RM had been trained on client A's BSP. The retraining on client A's BSP currently being done at the home observed on 11/6/13 at 4:30 P.M. indicated staff at the home were receiving a copy of client A's BSP and signing their name indicating they had read the BSP for client A. The training records did not indicate who was responsible for ensuring the staff were trained to implement client plans.</p> <p>2. Client B's record was reviewed on 11/7/13 at 3:02 P.M. Client B's record indicated "[Client B] is a high fall risk...Keep areas clear of clutter. Keep rooms well lighted. Use gait belt and when walking or transferring [client B]. Use walker when [client B] is ambulating. Staff will check to make sure gait belt is on correctly before walking or</p>			

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	<p>transferring...remind not to loosen gait belt."</p> <p>An interview was conducted with the Qualified Intellectual Disabilities Professional (QIDP) on 11/8/13 at 10:49 A.M. The QIDP stated, "It is not in her plan, but she is a one on one assist when she ambulates or transfers. You have to hang on to her (client B's) gait belt at all times when she is standing and walking."</p> <p>An interview was conducted with the QIDP on 11/8/13 at 10:25 A.M. The QIDP stated, "No, staff did not follow his (client A's) BSP or diet. After a few hours a transport carry technique should have been used. There was only one staff working, so staff could not do the transport carry technique. There are other things they should have tried, like giving him a bag of groceries to carry in, or his book bag." The QIDP indicated staff working on 10/20/13 had been a temp staff. The QIDP stated, "Staff had taken the power point training prior to working at the home, I don't know about training on BSP. I will need some time to look for the training sheets. She (DCS #3) has worked at the home before." The QIDP indicated it would take two staff to assist client A if the carry transport technique had to be utilized and one staff to work one on one with client B. The QIDP</p>			

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	<p>indicated she did not know who would be assisting the other three residents in the home. The QIDP indicated she did not know what changes had been made or were going to be made to the department systems. The QIDP indicated there was no documentation available for review to indicate what changes had been made to the Residential Department System.</p> <p>This federal tag relates to complaint #IN00138596.</p> <p>9-3-3(a)</p>			

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W000240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, record review and interview, the facility failed to specify in the fall risk plan the level of staff supervision needed for 1 of 3 sampled clients (client B) to assist in preventing her from falling.</p> <p>Findings include:</p> <p>Observations were conducted at the home where client B lived on 11/6/13 from 3:25 P.M. through 5:20 P.M. Direct Care Staff (DCS) #1 and the Residential Manger (RM) were observed assisting client B each time she ambulated throughout the home. DCS #1 and the RM held on to a gait belt which client B was wearing as client B used her roller walker. The RM and DCS #1 stabilized and balanced client B by using the gait belt. They also assisted client B up/down off of the city bus, into the home, off of the sofa and chairs. The RM and DCS #1 would ask for stand by assistance for client B from each other anytime they had to leave the area client B was sitting in.</p> <p>An interview was conducted with the RM on 11/6/13 at 4:53 P.M. The RM stated, "She (client B) is to always have a staff</p>	W000240	<p>Client B's fall risk plan will be updated to reflect that she needs one on one assistance when standing or walking. Person Responsible: Agency Nurse Completion Date: December 15, 2013 Group homestaff will be trained on client B's updated risk plan. Person Responsible: QIDP Completion Date: December 15, 2013 The nurse will review the all clients' risk plans once per month for the next 3 months to ensure that all risk plans address all the required interventions. The nurse will complete a checklist to indicate that this was done. The assistant director will review the checklist monthly. Person Responsible: Agency Nurse Completion Date: December 15, 2013</p>	12/15/2013	

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	<p>with her at all times so she doesn't fall."</p> <p>An interview was conducted with DCS #1 on 11/6/13 at 4:07 P.M. DCS #1 stated, "We are to walk with her and stay close to her at all times so she doesn't try to walk by herself."</p> <p>Client B's record was reviewed on 11/7/13 at 3:02 P.M. Client B's record indicated "[Client B] is a high fall risk...Keep areas clear of clutter. Keep rooms well lighted. Use gait belt and when walking or transferring [client B]. Use walker when [client B] is ambulating. Staff will check to make sure gait belt is on correctly before walking or transferring...remind not to loosen gait belt."</p> <p>An interview was conducted with the Qualified Intellectual Disabilities Professional (QIDP) on 11/8/13 at 10:49 A.M. The QIDP stated, "It is not in her plan, but she is a one on one assist when she ambulates or transfers. You have to hang on to her (client B's) gait belt at all times when she is standing and walking."</p> <p>9-3-4(a)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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