STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G392	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL SERVICES INC OF INDIANA	308 W MAIN ST SILVER LAKE, IN 46982

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0000	This visit was for the investigation of complaint #IN00104772. Complaint #IN00104772: Substantiated. Federal and state deficiencies related to the allegation(s) are cited at W122, W149, W154, W249, W287. Dates of Survey: March 7, 8, 12, 2012. Facility number: 000906 Provider number: 15G392 AIM number: 100235160 Surveyor: Susan Reichert, Medical Surveyor III The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/22/12 by Ruth Shackelford, Medical Surveyor III.	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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W0122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections. The facility failed to protect 1 of 4 sampled clients (client A) from self injurious behavior, failed to implement her plan to address pica and self injurious behavior after she was identified with the potential to ingest inedible objects and engage in self injurious behavior using objects, and failed to document a thorough investigation into 1 of 1 investigation reviewed involving client A. Findings include: Please see W149. The facility neglected to implement written policy and procedures to protect 1 of 4 sampled clients (client A) from self injurious behavior, failed to implement her plan to address pica and self injurious behavior after she was identified with the potential to ingest inedible objects and engage in self injurious behavior using objects, and failed to document a thorough investigation into 1 of 1 investigation reviewed involving client A.	W0122	**W122** The facility must ensure that specific client protections requirements are met. Cardinal Services, Inc. strives to meet and be in compliance with all of the conditions of participation established by the Secretary of Health and Human Services. This allegation of compliance is intended to show Cardinal Services' commitment to quality delivery of services. Proactive strategies and corrective action have been developed as needed to avoid further incidents. It is Cardinal Services' belief that the corrective action taken by management staff and the QDP has resolved the problems created by the condition out of compliance. Please see W149	04/09/2012

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	This federal tag relates to complaint #IN00104772. 9-3-2(a)			

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W0149	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, observation and interview, the facility neglected to implement written policy and procedures to protect 1 of 4 sampled clients (client A) from self injurious behavior, failed to implement her plan to address pica and self injurious behavior after she was identified with the potential to ingest inedible objects and engage in self injurious behavior using objects, and failed to document a thorough investigation into 1 of 1 investigation reviewed involving client A. Findings include: The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 3/7/12 at 1:16 PM. A report dated 1/29/12 indicated at 7:50 AM client A was observed in her bed with her head under her covers and "appeared to be sleeping. Right before 8:00 AM, staff went back into the room and observed [client A] holding a bracelet in her mouth. Staff immediately was able to get the bracelet away and found that 4 of her teeth were missing. [Client A] also attempted to pull out one of her teeth with her fingers." The report indicated client A was taken to the emergency room and released, and her behavior plan was followed at the time of the incident. A 2/14/12 follow up report indicated client A was seen by the dentist on 1/31/12 and indicated client A had bone loss and "it was possible this was bothering [client A] and that is why she removed the teeth. The dentist did not think the potential irritation or pain from this would have been enough to cause this	W0149	**W149** The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. On March 8, 2012 Client A's Self-Management plan was amended through IDT notes to clarify her supervision requirements due to PICA issues. (See Attachment A) On March 15, 2012 a thorough clarification was written for Client A's Self-Management Plan through IDT notes to state; 1. The types of personal items that should be locked for her safety 2. That Client A will continue to be monitored through use of the HRC and Guardian approved video monitoring 3. That should the video monitor malfunction, Client A will be given the option of sleeping in her bed with staff joining her in her room or she can choose to sleep in her recliner 4. The level of staff supervision for Client A based on the activity she is involved in. 14 West staff was trained on the plan clarifications by March 19, 2012. (See Attachment B) Day Program staff was trained on the plan clarifications on March 22, 2012. (See Attachment C) On March 28, 2012 Cardinal Services Inc. Investigation Procedures for	04/09/2012

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	kind of behavior though." The report indicated client A's psychiatrist had reviewed her chart and adjusted her medication and "believes this will help [client A] to control her obsessive behavior." The report indicated client A had a history of "mild to moderate" self injurious behavior of biting her hand or tongue. "[Client A] also has a history of PICA (sic) and her self management plan addresses this through close observation and 10 minute bed checks when [client A] is in her bedroom. Staff were following [client A's] plan at the time of the this incident. The IDT (interdisciplinary team) immediately implemented safety measures of locking all personal items and roommate's items that could cause harm to [client A] and constant eyesight supervision for [client A]. The IDT determined that it would less invasive to [client A] and her roommate to provide video monitoring of [client A] while she is in her bedroom while [client A] struggles with this issue...Once the video monitoring begins, personal items will no longer be locked and [client A] will be given the opportunity to spend time in her room without staff present...If monitoring reveals continued use of objects to harm herself, staff will intervene immediately and personal items will be locked again." A follow up report dated 2/23/12 indicated a plan to use protective mitts was in place for client A and staff had been trained on the plans to utilize video monitoring and mitts to protect client A. Client A was observed at day services on 3/7/12 from 1:50 PM until 2:21 PM. During the observation, client A was given a packet of buttons to choose one for a craft project, and 6 buttons were left on the table in front of client A within arms reach after client A selected a button with a metallic rim to glue on her project. Staff #1 and #2 were within eyesight, but not arms reach after the buttons were left on the table in front of		Persons Served were revised to state that the investigation must include the investigator's name and signature, names of witnesses, witness statements, dates and a summary/conclusion of the investigation. All Residential Managers were trained on the updated procedure by March 30, 2012. (See attachment D) All staff will receive training on the revised Investigation Procedures by April 9, 2012. On March 28, 2012 Cardinal Services Inc.'s Incident Reporting Policy and Procedure was revised to include the statement, "Refer to Investigation Procedure-Person Served" regarding the follow up responsibility of Managers. All Residential Managers were trained on the Policy revision by March 30, 2012. (See Attachment E) All staff will be trained on the Policy revision by April 9, 2012. By March 9, 2011 14 West staff received training stating that staff must not have Client A sleep in her recliner for staff convenience. (See Attachment F) All staff will receive training stating that techniques to manage inappropriate behavior must never be used for the convenience of staff by April 9, 2012. (See attachment G) To ensure this deficiency does not occur again, the Residential Manager, QDP and Residential Coordinator will monitor the implementation of all	

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	client A. Staff #2 turned her back on client A while she obtained supplies in a cabinet and glasses for snack while client A sat at a table with her completed craft project which included the metallic button and two containers of more than 12 markers each with removable caps. Staff #1 was interviewed on 3/7/12 at 2:14 PM and indicated client A was to be one to one supervision due to pica behavior and stated client A "has been going through issues," and had ingested a metal tag in the past. Residential Coordinator #1 (RC #1) was interviewed on 3/7/12 at 2:20 PM and indicated client A was to be under eyesight supervision at all times and every 10 minutes while in her bedroom. She indicated video monitoring for client A had been implemented as of 2/17/12 while she was in her bedroom, and small items of personal possessions of client A that could potentially be put into her mouth were to be locked. She indicated staff should keep client A in their eyesight at all times and staff should not turn their back on client A. Staff #2 was interviewed on 3/7/12 at 3:18 PM and indicated client A should have been within eyesight supervision while she was in day services, and she was in error in turning her back on client A to get supplies. An investigation into the incident on 1/29/12 involving client A was reviewed on 3/7/12 at 2:30 PM. The investigation was unsigned and did not include a summary or conclusion as to how client A was able to pull 4 teeth from her mouth in a span of less than 10 minutes, why she may have pulled her teeth or the whereabouts of client A's extracted teeth. The investigation indicated client A was found with a bracelet in her mouth, but did		individualized plans and agency Policies through weekly, monthly and quarterly observations. (See Attachment H) **QDP, Residential Manager and Residential Coordinator Responsible.**	

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	not include how client A obtained the bracelet. RC #1 was interviewed on 3/7/12 at 3:00 PM and indicated client A's supervision level was to be within staff eyesight and every 10 minutes while in her bedroom at the time of the incident. She indicated client A's personal items were not locked at the time of the incident and the bracelet found with client A on 1/29/12 was client A's possession. She indicated client A had been experiencing increased behaviors since a medication she had been taking had been discontinued due to side effects about a year ago. She indicated IDT addendums had been added to client A's plan to address her behavior of pulling her teeth and included the use of a video monitor, locking of client A's personal items and the use of mitts to prevent her from pulling her teeth. She indicated the mitts had not been used. Client A's record was reviewed on 3/7/12 at 2:30 PM. A Self Management Plan dated 9/30/11 indicated pica in a functional analysis, "Examples of PICA for me, includes, but is not limited to dust particles, strings, tags on clothing and other items, small objects, such as Lego's, buttons, and others (sic), metal items including metal tags, and in the past pieces of glass, gloves and bandages. I also exhibit licking floors, windows, walls or tables and may nibble on corners or scrape my teeth on these items and swallow what I scrape off these items...." Self injurious behavior (SIB) and physical aggression were also included in the functional analysis and indicated, "While my self-abuse has not been severe enough to require medical attention, it often occurs right before or during times I am being aggressive. My SIB usually consists of biting my tongue and hands." Interventions for PICA included "staff will keep me within eyesight during all waking hours to observe and immediately redirect me from the			

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	non-food items or attempts to gain such items...." IDT notes dated 1/31/12 indicated client A had removed "at least four teeth with her solid bracelet," and 2 of the 4 teeth had been found. "IDT discussed and approved the temporary measure of permitting [client A] to sleep in her reclining chair in the living room to facilitate consistent monitoring to further ensure [client A's] safety. IDT further discussed the need to remove all bracelets and other items from the bedroom and lock these away from the consumer...." A note dated 2/13/12 indicated client A would continue to be on close observation and client A would be monitored through a purchased video device approved by the guardian and HRC (Human Rights Committee) members to ensure her safety and prevention of SIB during "asleep" times. An IDT note dated 2/20/12 indicated "IDT discussed the incident of 2/13/12 and other occurrences of attempted placing of her hands in her mouth to access her teeth. IDT considered alternatives for [client A] and it was found that protective mitts would be used with consent of guardian and HRC (human rights committee) members to protect [client A] from pulling and possibly eating her teeth that remain... It was decided that the mitts would be placed on her hands...she will continue to be observed and will be released every 15 minutes or sooner as she regains her calm and does not attempt to pull her own teeth or to access the oral areas where the previous teeth were pulled....The protective mitts are to be used as needed to assist [client A] to remain safe and to not indulge in Self Injurious Behavior." During the observation at the group home on 3/7/12 from 4:30 PM until 5:20 PM, client A was in constant eyesight supervision by staff. There was a metal bracelet on client A's dresser, two plastic beaded necklaces and two bottles of nail polish.			

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	The house manager was interviewed on 3/7/12 at 4:40 PM. When asked about the bracelet on client A's dresser, she indicated bracelets were not to be available to client A, and stated, "I didn't even see this one. It's not supposed to be here." She indicated the necklaces and polish were OK to have in client A's room and indicated only bracelets were to be locked at this time. During the observation at the group home on 3/8/12 from 4:33 AM until 5:50 AM, client A was laying on a recliner by the front door with a blanket over her head from 4:33 AM until 5:00 AM when she went with staff to take a shower and remained in eyesight of staff throughout the duration of the observation. Behavior rates for client A's pica and self injurious behavior were reviewed on 3/8/12 at 10:30 AM. The records indicated client A had attempted to pull at her teeth on 2/9/12, 2/10/12, and on 2/13/12 attempted to pull her teeth and tear at her gums for 2.25 hours, on 2/14/12 picked at her gums and teeth, and on 2/16/12 "picking at gums to make them bleed." A note on the back of the tracking form for January, 2012 dated 1/29/12 indicated "[client A] has obsessed over pop, her bracelets, and items on [roommate client D's] dresser today...At her 7:50 AM bed check, I went in to see her sitting up in bed, with broken bracelets in her hands gouging at her mouth. There was blood everywhere. We got her cleaned up and realized she had somehow pulled some teeth out. Since she has come back from ER (emergency room), she has continuously tried to either pull more teeth or get her gums to bleed again. She tries to put objects in her mouth like she's trying to pry more teeth out." An entry dated 1/30/12 indicated client A was attempting to pull on her teeth in the evening.			

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	The Support Services Coordinator (SSC) and RC #1 were interviewed on 3/8/12 at 9:30 AM. When asked if client A's plan was implemented when staff turned their back on her to get supplies at day services and a bracelet was available in client A's room, the SSC stated "It was reasonable for staff to turn their back on [client A] given the items on the table," and indicated client A's pica usually involved "dust bunnies." She stated the metallic buttons within access to client A during observations at day services on 3/7/12 were "not a concern," and indicated the pica items listed for client A in her self management plan that included buttons were historical. She indicated client A's plan would be updated to clarify her supervision needs. The RC #1 indicated client A was to be within eyesight based upon her current plan and stated based upon her current plan the metal bracelet "shouldn't be there" (in client A's bedroom). She indicated client A had tapped her teeth against or ran her teeth over the metal bracelets in the past. IDT notes dated 3/8/12 were reviewed on 3/12/12 at 4:45 PM and indicated it was an update to client A's plan and included an excerpt from her plan, "Staff will keep me within eyesight during all waking hours..." with the clarification, "A staff will be in the room or area with [client A] and maintain a heightened awareness of her activity. If [client A] is relaxing in a chair or in an area of the room that is free from items that she could potentially harm herself with staff may turn to assist [client A's] peers or complete other tasks as long as they are able to be aware if [client A] should choose to move to another area or attempt to cross the room to obtain something that may harm her. If [client A] is working on a task or activity using objects that she could potentially use to harm herself staff must be able to consistently			

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	visually observe her and be close enough to intervene should she make the attempt to engage in PICA or self-injurious behavior." A BDDS report dated 8/30/11 reviewed on 3/12/12 at 5:15 PM indicated client A had incurred scratches to her lip after she ingested two adhesive backed metal tags used to inventory property. The report indicated client A had removed the tags by scraping her teeth against them. RC #2 was interviewed on 3/12/12 at 4:55 PM and indicated there had been no incidents of ingesting edibles for client A since the 8/30/11 incident. A review of the facility's "Incident/Abuse/Neglect Policy", dated 3/11 on 3/7/12 at 4:00 PM, indicated, the agency "is committed to ensuring the safety, dignity, and protections of persons served." The Investigation Procedure-Person Served dated 1/11 indicated supervisors were to complete the investigation within 24 hours, gather witness statements including the person served if possible, maintain notes and ensure all environments are safe. The policy and procedures did not indicate the need to identify the investigator or include a summary/conclusion of the investigation. This federal tag relates to complaint #IN00104772. 9-3-2(a)			

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W0154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review, observation and interview, the facility failed to document a thorough investigation into 1 of 1 investigation reviewed involving client A. Findings include: The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 3/7/12 at 1:16 PM. A report dated 1/29/12 indicated at 7:50 AM client A was observed in her bed with her head under her covers and "appeared to be sleeping. Right before 8:00 AM, staff went back into the room and observed [client A] holding a bracelet in her mouth. Staff immediately was able to get the bracelet away and found that 4 of her teeth were missing. [Client A] also attempted to pull out one of her teeth with her fingers." The report indicated client A was taken to the emergency room and released, and her behavior plan was followed at the time of the incident. A 2/14/12 follow up report indicated client A was seen by the dentist on 1/31/12 and indicated client A had bone loss and "it was possible this was bothering [client A]	W0154	**W154** The facility must have evidence that all alleged violations are thoroughly investigated. On March 28, 2012 Cardinal Services Inc. Investigation Procedures for Persons Served were revised to state that the investigation must include the investigator's name and signature, names of witnesses, witness statements, dates and a summary/conclusion of the investigation. All Residential Managers were trained on the updated procedure by March 30, 2012. (See attachment D) All staff will receive training on the revised Investigation Procedures by April 9, 2012. On March 28, 2012 Cardinal Services Inc.'s Incident Reporting Policy and	04/09/2012

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	and that is why she removed the teeth. The dentist did not think the potential irritation or pain from this would have been enough to cause this kind of behavior though." The report indicated client A's psychiatrist had reviewed her chart and adjusted her medication and "believes this will help [client A] to control her obsessive behavior." The report indicated client A had a history of "mild to moderate" self injurious behavior of biting her hand or tongue. "[Client A] also has a history of PICA (sic) and her self management plan addresses this through close observation and 10 minute bed checks when [client A] is in her bedroom. Staff were following client [A's] plan at the time of the this incident. The IDT (interdisciplinary team) immediately implemented safety measures of locking all personal items and roommate's items that could cause harm to [client A] and constant eyesight supervision for [client A]. The IDT determined that it would less invasive to [client A] and her roommate to provide video monitoring of [client A] while she is in her bedroom while [client A] struggles with this issue...Once the video monitoring begins, personal items will no longer be locked and [client A] will be given the opportunity to spend time in her room without staff present...If monitoring reveals continued use of objects to harm		Procedure was revised to include the statement, “Refer to Investigation Procedure-Person Served” regarding the follow up responsibility of Managers. All Residential Managers were trained on the Policy revision by March 30, 2012. (See Attachment E) All staff will be trained on the Policy revision by April 9, 2012. In order to ensure that this deficiency does not occur again the Residential Coordinator will assure that Investigation Notes are reviewed and attached to appropriate Incident Reports. **Residential Manager and Residential Coordinator Responsible**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G392	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/12/2012
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	herself, staff will intervene immediately and personal items will be locked again." A follow up report dated 2/23/12 indicated a plan to use protective mitts was in place for client A and staff had been trained on the plans to utilize video monitoring and mitts to protect client A. An investigation into the incident on 1/29/12 involving client A was reviewed on 3/7/12 at 2:30 PM. The investigation was unsigned and did not include a summary or conclusion as to how client A was able to pull 4 teeth from her mouth in a span of less than 10 minutes, why she may have pulled her teeth, the whereabouts of client A's extracted teeth, and did not include how client A obtained the bracelet or who had completed the investigation. The investigation indicated client A was found with a bracelet in her mouth and four of her teeth missing at 8:00 AM after a 7:50 AM check upon where she was observed in bed and appeared to be asleep. Behavior rates for client A's pica and self injurious behavior were reviewed on 3/8/12 at 10:30 AM. A note on the back of the tracking form for January, 2012 dated 1/29/12 indicated "[client A] has obsessed over pop, her bracelets, and items on [roommate client D's] dresser today...At her 7:50 AM bed check, I went			

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	in to see her sitting up in bed, with broken bracelets in her hands gouging at her mouth. There was blood everywhere. We got her cleaned up and realized she had somehow pulled some teeth out. Since she has come back from ER (emergency room), she has continuously tried to either pull more teeth or get her gums to bleed again. She tries to put objects in her mouth like she's trying to pry more teeth out." An entry dated 1/30/12 indicated client A was attempting to pull on her teeth in the evening. The Support Services Coordinator (SSC) and RC #1 were interviewed on 3/8/12 at 9:30 AM. When asked if the discrepancy between the time client A was checked and then found with her teeth pulled listed in the staff note on 1/29/12 and the time listed in the BDDS report had been investigated, she indicated they had not been investigated and stated, the staff was "probably rattled or shaken." She stated client A was "amazingly strong" and her teeth "were not in great shape," and not much force was possibly needed to pull her teeth. She indicated the whereabouts of client A's other two teeth was unknown. She indicated no further investigation was documented into the incident involving client A pulling her teeth on 1/29/12 and no summary or conclusion was written, or was the			

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	investigator identified in the investigation. This federal tag relates to complaint #IN00104772. 9-3-2(a)			

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W0249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on record review, observation and interview, the facility failed to implement 1 of 4 sampled clients (client A's) plan to address pica and self injurious behavior. Findings include: The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 3/7/12 at 1:16 PM. A report dated 1/29/12 indicated at 7:50 AM client A was observed in her bed with her head under her covers and "appeared to be sleeping. Right before 8:00 AM, staff went back into the room and observed [client A] holding a bracelet in her mouth. Staff immediately was able to get the bracelet away and found that 4 of her teeth were missing. [Client A] also attempted to pull out one of her teeth with her fingers." The report indicated client A was taken to the emergency room and released, and her behavior plan was followed at the time of the incident. A	W0249	**W249** As soon as the interdisciplinary team has formulated a client's individual program plan each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. On March 3, 2012 Client A's Self-Management plan was amended through IDT notes to clarify her supervision requirements due to PICA issues.(See Attachment A) On March 15, 2012 a thorough clarification was written for Client A's Self-Management Plan through IDT notes to state; 1. The types of personal	04/09/2012

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	2/14/12 follow up report indicated client A was seen by the dentist on 1/31/12 and indicated client A had bone loss and "it was possible this was bothering [client A] and that is why she removed the teeth. The dentist did not think the potential irritation or pain from this would have been enough to cause this kind of behavior though." The report indicated client A's psychiatrist had reviewed her chart and adjusted her medication and "believes this will help [client A] to control her obsessive behavior." The report indicated client A had a history of "mild to moderate" self injurious behavior of biting her hand or tongue. "[Client A] also has a history of PICA (sic) and her self management plan addresses this through close observation and 10 minute bed checks when [client A] is in her bedroom. Staff were following [client A's] plan at the time of the this incident. The IDT (interdisciplinary team) immediately implemented safety measures of locking all personal items and roommate's items that could cause harm to [client A]and constant eyesight supervision for [client A]. The IDT determined that it would less invasive to [client A] and her roommate to provide video monitoring of [client A] while she is in her bedroom while [client A] struggles with this issue...Once the video monitoring begins, personal items will no		items that should be locked for her safety 2. That Client A will continue to be monitored through use of the HRC and Guardian approved video monitoring 3. That should the video monitor malfunction, Client A will be given the option of sleeping in her bed with staff joining her in her room or she can choose to sleep in her recliner 4. The level of staff supervision for Client A based on the activity she is involved in. 14 West staff was trained on the plan clarifications by March 19, 2012. (See Attachment B) Day Program staff was trained on the plan clarifications on March 22, 2012. (See Attachment C) To ensure this deficiency does not occur again, the Residential Manager, QDP and Residential Coordinator will monitor the implementation of all individualized plans through weekly, monthly and quarterly observations. (See Attachment H)	

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	longer be locked and [client A] will be given the opportunity to spend time in her room without staff present...If monitoring reveals continued use of objects to harm herself, staff will intervene immediately and personal items will be locked again." A follow up report dated 2/23/12 indicated a plan to use protective mitts was in place for client A and staff had been trained on the plans to utilize video monitoring and mitts to protect client A. Client A was observed at day services on 3/7/12 from 1:50 PM until 2:21 PM. During the observation, client A was given a packet of buttons to choose one for a craft project, and 6 buttons were left on the table in front of client A within arms reach after client A selected a button with a metallic rim to glue on her project. Staff #1 and #2 were within eyesight, but not arms reach after the buttons were left on the table in front of client A. Staff #2 turned her back on client A while she obtained supplies in a cabinet and glasses for snack while client A sat at a table with her completed craft project which included the metallic button and two containers of more than 12 markers each with removable caps. Staff #1 was interviewed on 3/7/12 at 2:14 PM and indicated client A was to be one to one supervision due to pica		**QDP, Residential Manager and Residential Coordinator Responsible**	

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	behavior and stated client A "has been going through issues," and had ingested a metal tag in the past. Residential Coordinator #1 (RC #1) was interviewed on 3/7/12 at 2:20 PM and indicated client A was to be under eyesight supervision at all times and every 10 minutes while in her bedroom. She indicated video monitoring for client A had been implemented as of 2/17/12 while she was in her bedroom, and small items of personal possessions of client A that could potentially be put into her mouth were to be locked. She indicated staff should keep client A in their eyesight at all times and staff should not turn their back on client A. Staff #2 was interviewed on 3/7/12 at 3:18 PM and indicated client A should have been within eyesight supervision while she was in day services, and she was in error in turning her back on client A to get supplies. RC #1 was interviewed on 3/7/12 at 3:00 PM and indicated client A's supervision level was to be within staff eyesight and every 10 minutes while in her bedroom at the time of the incident. She indicated client A's personal items were not locked at the time of the incident and the bracelet found with client A on 1/29/12 was client			

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	A's possession. She indicated client A had been experiencing increased behaviors since a medication she had been taking had been discontinued due to side effects about a year ago. She indicated IDT addendums had been added to client A's plan to address her behavior of pulling her teeth and included the use of a video monitor, locking of client A's personal items and the use of mitts to prevent her from pulling her teeth. She indicated the mitts had not been used. Client A's record was reviewed on 3/7/12 at 2:30 PM. A Self Management Plan dated 9/30/11 indicated pica in a functional analysis, "Examples of PICA for me, includes, but is not limited to dust particles, strings, tags on clothing and other items, small objects, such as Lego's, buttons, and others (sic), metal items including metal tags, and in the past pieces of glass, gloves and bandages. I also exhibit licking floors, windows, walls or tables and may nibble on corners or scrape my teeth on these items and swallow what I scrape off these items...." Self injurious behavior (SIB) and physical aggression were also included in the functional analysis and indicated, "While my self-abuse has not been severe enough to require medical attention, it often occurs right before or during times I am			

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	being aggressive. My SIB usually consists of biting my tongue and hands." Interventions for PICA included "staff will keep me within eyesight during all waking hours to observe and immediately redirect me from the non-food items or attempts to gain such items...." IDT notes dated 1/31/12 indicated client A had removed "at least four teeth with her solid bracelet," and 2 of the 4 teeth had been found. "IDT discussed and approved the temporary measure of permitting [client A] to sleep in her reclining chair in the living room to facilitate consistent monitoring to further ensure [client A's] safety. IDT further discussed the need to remove all bracelets and other items from the bedroom and lock these away from the consumer...." A note dated 2/13/12 indicated client A would continue to be on close observation and client A would be monitored through a purchased video device approved by the guardian and HRC members to ensure her safety and prevention of SIB during "asleep" times. An IDT note dated 2/20/12 indicated "IDT discussed the incident of 2/13/12 and other occurrences of attempted placing of her hands in her mouth to access her teeth. IDT considered alternatives for [client A] and it was found that protective mitts would be used with consent of guardian and HRC (human rights committee) members to			

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	protect [client A] from pulling and possibly eating her teeth that remain... It was decided that the mitts would be placed on her hands...she will continue to be observed and will be released every 15 minutes or sooner as she regains her calm and does not attempt to pull her own teeth or to access the oral areas where the previous teeth were pulled....The protective mitts are to be used as needed to assist [client A] to remain safe and to not indulge in Self Injurious Behavior." During the observation at the group home on 3/7/12 from 4:30 PM until 5:20 PM, client A was in constant eyesight supervision by staff. There was a metal bracelet on client A's dresser, two plastic beaded necklaces and two bottles of nail polish. The house manager was interviewed on 3/7/12 at 4:40 PM. When asked about the bracelet on client A's dresser, she indicated bracelets were not to be available to client A, and stated, "I didn't even see this one. It's not supposed to be here." She indicated the necklaces and polish were OK to have in client A's room and indicated only bracelets were to be locked at this time. The RC #1 indicated client A was to be within eyesight based upon her current			

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	plan and stated based upon her current plan the metal bracelet "shouldn't be there" (in client A's bedroom). She indicated client A had tapped her teeth against or ran her teeth over the metal bracelets in the past. IDT notes dated 3/8/12 were reviewed on 3/12/12 at 4:45 PM indicated it was an update to client A's plan and included an excerpt from her plan, "Staff will keep me within eyesight during all waking hours..." with the clarification, "A staff will be in the room or area with [client A] and maintain a heightened awareness of her activity. If [client A] is relaxing in a chair or in an area of the room that is free from items that she could potentially harm herself with staff may turn to assist [client A's] peers or complete other tasks as long as they are able to be aware if [client A] should choose to move to another area or attempt to cross the room to obtain something that may harm her. If [client A] is working on a task or activity using objects that she could potentially use to harm herself staff must be able to consistently visually observe her and be close enough to intervene should she make the attempt to engage in PICA or self-injurious behavior." This federal tag relates to complaint #IN00104772.			

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W0287	483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used for the convenience of staff. Based on record review, observation and interview, the facility failed to ensure client A's sleeping in a recliner was not for staff convenience to meet her supervision needs while a behavior plan was being developed to protect her from engaging in self injurious behavior. Findings include: The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 3/7/12 at 1:16 PM. A report dated 1/29/12 indicated at 7:50 AM client A was observed in her bed with her head under her covers and "appeared to be sleeping. Right before 8:00 AM, staff went back into the room and observed [client A] holding a bracelet in her mouth. Staff immediately was able to get the bracelet away and found that 4 of her teeth were missing. [Client A] also attempted to pull out one of her teeth with her fingers." The report indicated client A was taken to the emergency room and released, and her behavior plan was followed at the time of the incident. A 2/14/12 follow up report indicated client	W0287	**W287** Techniques to manage inappropriate client behavior must never be used for the convenience of staff. By March 9, 2011 14 West staff received training stating that staff must not have Client A sleep in her recliner for staff convenience. (See Attachment F) All staff will receive training stating that techniques to manage inappropriate behavior must never be used for the convenience of staff by April 9, 2012. (See attachment G) To ensure this deficiency does not occur again, the Residential Manager, QDP and Residential Coordinator will monitor the	04/09/2012

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	A was seen by the dentist on 1/31/12 and indicated client A had bone loss and "it was possible this was bothering [client A] and that is why she removed the teeth. The dentist did not think the potential irritation or pain from this would have been enough to cause this kind of behavior though." The report indicated client A's psychiatrist had reviewed her chart and adjusted her medication and "believes this will help [client A] to control her obsessive behavior." The report indicated client A had a history of "mild to moderate" self injurious behavior of biting her hand or tongue. "[Client A] also has a history of PICA (sic) and her self management plan addresses this through close observation and 10 minute bed checks when [client A] is in her bedroom. Staff were following [client A's] plan at the time of the this incident. The IDT (interdisciplinary team) immediately implemented safety measures of locking all personal items and roommate's items that could cause harm to [client A] and constant eyesight supervision for [client A]. The IDT determined that it would less invasive to [client A] and her roommate to provide video monitoring of [client A] while she is in her bedroom while [client A] struggles with this issue...Once the video monitoring begins, personal items will no longer be locked and [client A] will be		implementation of all individualized plans and agency Policies through weekly, monthly and quarterly observations. (See Attachment H) **QDP, Residential Manager and Residential Coordinator Responsible**	

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	given the opportunity to spend time in her room without staff present...If monitoring reveals continued use of objects to harm herself, staff will intervene immediately and personal items will be locked again." A follow up report dated 2/23/12 indicated a plan to use protective mitts was in place for client A and staff had been trained on the plans to utilize video monitoring and mitts to protect client A. RC #1 was interviewed on 3/7/12 at 3:00 PM and indicated client A's supervision level was to be within staff eyesight and every 10 minutes while in her bedroom at the time of the incident. She indicated IDT addendums had been added to client A's plan to address her behavior of pulling her teeth and included the use of a video monitor, locking of client A's personal items and the use of mitts to prevent her from pulling her teeth. She indicated the mitts had not been used. Client A's record was reviewed on 3/7/12 at 2:30 PM. A Self Management Plan dated 9/30/11 indicated pica in a functional analysis, "Examples of PICA for me, includes, but is not limited to dust particles, strings, tags on clothing and other items, small objects, such as Lego's, buttons, and others (sic), metal items including metal tags, and in the past pieces of glass, gloves and bandages. I			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G392	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/12/2012
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	also exhibit licking floors, windows, walls or tables and may nibble on corners or scrape my teeth on these items and swallow what I scrape off these items...." Self injurious behavior (SIB) and physical aggression were also included in the functional analysis and indicated, "While my self-abuse has not been severe enough to require medical attention, it often occurs right before or during times I am being aggressive. My SIB usually consists of biting my tongue and hands." Interventions for PICA included "staff will keep me within eyesight during all waking hours to observe and immediately redirect me from the non-food items or attempts to gain such items...." IDT notes dated 1/31/12 indicated client A had removed "at least four teeth with her solid bracelet," and 2 of the 4 teeth had been found. "IDT discussed and approved the temporary measure of permitting [client A]to sleep in her reclining chair in the living room to facilitate consistent monitoring to further ensure [client A's] safety. IDT further discussed the need to remove all bracelets and other items from the bedroom and lock these away from the consumer...." A note dated 2/13/12 indicated client A would continue to be on close observation and a client A would be monitored through a purchased video device approved by the guardian and HRC members to ensure her safety and			

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	prevention of SIB during "asleep" times. An IDT note dated 2/20/12 indicated "IDT discussed the incident of 2/13/12 and other occurrences of attempted placing of her hands in her mouth to access her teeth. IDT considered alternatives for [client A] and if was found that protective mitts would be used with consent of guardian and HRC (human rights committee) members to protect [client A] from pulling and possibly eating her teeth that remains... It was decided that the mitts would be placed on her hands...she will continue to be observed and will be released every 15 minutes or sooner as she regains her calm and does not attempt to pull her own teeth or to access the oral areas where the previous teeth were pulled....The protective mitts are to be used as needed to assist [client A]to remain safe and to not indulge in Self Injurious Behavior." Client A's records in the group home were reviewed on 3/7/12 at 5:05 PM. A review of bedroom checks dated 2/15/12 indicated "under constant supervision. Slept in living room, on 2/16/12 under constant supervision, slept in living room, on 2/17/12, sleeping in living room. Under constant supervision, on 2/18/12 sleeping in living room-under constant supervision."			

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	The house manager was interviewed on 3/7/12 at 5:10 PM and stated client A had slept in a chair from 1/30/12 to 2/17/12 when the monitor was obtained, "plus a few days," because staff were concerned for her safety. When asked if client A preferred to sleep in a chair, she stated, "From what I understand, she liked it and wasn't prevented from sleeping in her bed, but I don't think it came up." During the observation at the group home on 3/8/12 from 4:33 AM until 5:50 AM, client A was laying on a recliner by the front door with a blanket over her head from 4:33 AM until 5:00 AM when she went with staff to take a shower and remained in eyesight of staff throughout the duration of the observation. Staff completed documentation at the dining room table while client A remained in the recliner. Staff #4 was interviewed on 3/8/12 at 4:33 AM. She stated client A's video monitor was malfunctioning, so "staff brought her out here to sleep so she could be monitored" and other assigned duties for staff could be completed. She indicated client A was to be under eyesight supervision when not in her bedroom being monitored with the video monitoring system.			

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	An Instruction Training document signed by staff on 3/8/12 and 3/9/12 was reviewed on 3/12/12 at 4:45 PM and indicated staff had "allowed [client A] the opportunity to sleep in her recliner in the living room to assure that staff could monitor her closely while providing for client A's privacy from January 30, 2012 to February 17, 2012....On 3/7/12, the video monitor failed to work and to assure for [client A's] safety and her roommate's privacy, staff allowed [client A] to once again sleep in her recliner. In the future should it become necessary for staff to be able to maintain consistent supervision of [client A] due to faulty video equipment or any other reason, staff must ask [client A] if she would prefer to sleep in her bed with staff in the room with her, sleep in her recliner or on the sofa. Staff must not have [client A] sleep in her recliner for staff convenience." Residential Coordinator #1 was interviewed on 3/8/12 at 9:30 AM and indicated client A slept in a chair rather than have staff sit with her during waking hours to protect client A's roommate's privacy. She indicated client A sometimes preferred to sleep in her chair. This federal tag relates to complaint #IN00104772.			

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