STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G410	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL SERVICES SUB LLC	103 E HANCOCK MITCHELL, IN 47446

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for a full annual recertification and state licensure survey. Survey Dates: January 12, 13, 14, 15, 19 and 20, 2016 Facility Number: 000924 Provider Number: 15G410 AIM Number: 100244510 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 1/26/16.	W 0000		
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on record review and interview for 8 of 8 clients living at the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to meet the Condition of Participation: Governing Body. The facility's governing body failed to exercise operating direction over the facility by failing to ensure client #1, #3, #4 and #7's program plans were integrated, coordinated and monitored from January 2015 to December 2015.	W 0102	The Program Director (QIDP) and Behavior Analyst were retrained on 2/1/16 on Program Plan Reviews, Monitoring and Implementation for ISP, BSP and Training Objectives. The PD (QIDP) will meet with the Area Director at least monthly to review any changes made to plans to ensure compliance. Client #1's Behavior Support Plan has been updated including the changes approved by guardian and staff	02/19/2016

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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	The governing body failed to ensure the clients' program plans were updated and revised when the clients achieved or failed to achieve the plans. The governing body failed to ensure the clients' training objectives were expressed in measurable indices of performance. The governing body failed to ensure client #1's program plans were updated/revised to reflect, starting on 12/1/15, client #1's guardian approved she could smoke cigarettes. The governing body failed to ensure client #1's program plans indicated the supervision level she needed while she was smoking. The governing body failed to ensure staff did not unnecessarily restrict client #1's access to a lighter. The governing body failed to ensure client #1's program plans indicated staff was to be outside with her while she smoked due to elopement. The governing body failed to ensure there was sufficient staff at the group home to prevent client #1 from eloping. The governing body failed to ensure there was a system in place to reconcile clients' savings accounts. The governing body failed to implement its policies and procedures to prevent client to client abuse, report an incident of possible financial exploitation to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner for client #3, report an incident of possible		have been trained on the updated plan both in the home and at the day program. Staffing schedules in the home have been updated to ensure there are sufficient staff at all times to prevent client #1 from eloping. The PD monitors the schedules weekly to ensure sufficient staff are on duty and staff in the home have been trained to contact a supervisor immediately if there are problems with sufficient staff when they are on duty. Savings account records have been obtained for all clients and accounts have all been reconciled and are accurate. The Program Coordinator (HM) was retrained on the process for obtaining the savings account records for clients monthly, reconciling home accounts at least three times per week for each client, and setting up a more accountable system for client monies sent to the day program each month. The Program Director will review savings account records at least monthly to ensure accuracy and will address discrepancies appropriately. Staff in the home will be retrained on preventing client to client abuse. Observations will be completed by supervisory staff at least three times per week to ensure staff are following the clients plans to prevent client to client abuse. The PD (QIDP) was retrained on Incident Reporting and	

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	financial exploitation to BDDS for client #4's missing money, initiate an investigation of client #3 and #4's missing money discovered during the survey, ensure there was sufficient staff to implement client #1's Behavioral Support Plan, conduct thorough investigations and take appropriate corrective actions to address client #1's elopement from the facility-operated day program. Findings include: 1) Please refer to W104. For 8 of 8 clients living at the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility's governing body failed to exercise operating direction over the facility by failing to ensure client #1, #3, #4 and #7's program plans were integrated, coordinated and monitored from January 2015 to December 2015. The governing body failed to ensure the clients' program plans were updated and revised when the clients achieved or failed to achieve the plans. The governing body failed to ensure the clients' training objectives were expressed in measurable indices of performance. The governing body failed to ensure client #1's program plans were updated/revised to reflect, starting on 12/1/15, client #1's guardian approved she could smoke cigarettes. The		Investigation Completion and Thoroughness and completing recommended corrective actions. The Area Director will review investigations with the Program Director weekly to ensure completion and thoroughness of investigations that occurred that week. Persons Responsible: Program Coordinator, Program Director (QIDP), Area Director	

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	governing body failed to ensure client #1's program plans indicated the supervision level she needed while she was smoking. The governing body failed to ensure staff did not unnecessarily restrict client #1's access to a lighter. The governing body failed to ensure client #1's program plans indicated staff was to be outside with her while she smoked due to elopement. The governing body failed to ensure there was sufficient staff at the group home to prevent client #1 from eloping. The governing body failed to ensure there was a system in place to reconcile clients' savings accounts. The governing body failed to implement its policies and procedures to prevent client to client abuse, report an incident of possible financial exploitation to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner for client #3, report an incident of possible financial exploitation to BDDS for an incident of possible exploitation to BDDS for client #4, initiate an investigation of client #3 and #4's missing money discovered during the survey, ensure there was sufficient staff to implement client #1's Behavioral Support Plan, ensure client #1's plan indicated staff was to supervise her in person when she went out to smoke, conduct thorough investigations and take appropriate corrective actions to address			

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	client #1's elopement from the facility-operated day program. 2) Please refer to W122. For 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to meet the Condition of Participation: Client Protections. The governing body neglected to implement its policies and procedures to prevent client to client abuse, report an incident of possible financial exploitation to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner for client #3, report an incident of possible financial exploitation to BDDS for an incident of possible exploitation to BDDS for client #4, initiate an investigation of client #3 and #4's missing money discovered during the survey, ensure there was sufficient staff to implement client #1's Behavioral Support Plan, ensure client #1's plan indicated staff was to supervise her in person when she went out to smoke, conduct thorough investigations and take appropriate corrective actions to address client #1's elopement from the facility-operated day program. 9-3-1(a)			

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W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 8 of 8 clients living at the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility's governing body failed to exercise operating direction over the facility by failing to ensure client #1, #3, #4 and #7's program plans were integrated, coordinated and monitored from January 2015 to December 2015. The governing body failed to ensure the clients' program plans were updated and revised when the clients achieved or failed to achieve the plans. The governing body failed to ensure the clients' training objectives were expressed in measurable indices of performance. The governing body failed to ensure client #1's program plans were updated/revised to reflect, starting on 12/1/15, client #1's guardian approved she could smoke cigarettes. The governing body failed to ensure client #1's program plans indicated the supervision level she needed while she was smoking. The governing body failed to ensure staff did not unnecessarily restrict client #1's access to a lighter. The governing body failed to ensure client #1's program plans indicated staff was to be outside with her while she smoked due	W 0104	The Program Director (QIDP) and Behavior Analyst were retrained on 2/1/16 on Program Plan Reviews, Monitoring and Implementation for ISP, BSP and Training Objectives. The PD (QIDP) will meet with the Area Director at least monthly to review any changes made to plans to ensure compliance. Client #1's Behavior Support Plan has been updated including the changes approved by guardian and staff have been trained on the updated plan both in the home and at the day program. Staffing schedules in the home have been updated to ensure there are sufficient staff at all times to prevent client #1 from eloping. The PD monitors the schedules weekly to ensure sufficient staff are on duty and staff in the home have been trained to contact a supervisor immediately if there are problems with sufficient staff when they are on duty. Savings account records have been obtained for all clients and accounts have all been reconciled and are accurate. The Program Coordinator (HM) was retrained on the process for obtaining the savings account records for clients monthly, reconciling home accounts at least three times per week for each client, and setting up a more	02/19/2016

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	to elopement. The governing body failed to ensure there was sufficient staff at the group home to prevent client #1 from eloping. The governing body failed to ensure there was a system in place to reconcile clients' savings accounts. The governing body failed to implement its policies and procedures to prevent client to client abuse, report an incident of possible financial exploitation to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner for client #3, report an incident of possible financial exploitation to BDDS for client #4, initiate an investigation of client #3 and #4's missing money discovered during the survey, ensure there was sufficient staff to implement client #1's Behavioral Support Plan, ensure client #1's plan indicated staff was to supervise her in person when she went out to smoke, conduct thorough investigations and take appropriate corrective actions to address client #1's elopement from the facility-operated day program. Findings include: 1) On 1/12/16 at 4:21 PM when the surveyor and the Program Coordinator (PC) counted the clients' finances for the survey, the PC indicated she did not have access to client #1, #2, #3, #4, #5, #6, #7 and #8's savings account information.		accountable system for client monies sent to the day program each month. The Program Director will review savings account records at least monthly to ensure accuracy and will address discrepancies appropriately. Staff in the home will be retrained on preventing client to client abuse. Observations will be completed by supervisory staff at least three times per week to ensure staff are following the clients plans to prevent client to client abuse. The PD (QIDP) was retrained on Incident Reporting and Investigation Completion and Thoroughness and completing recommended corrective actions. The Area Director will review investigations with the Program Director weekly to ensure completion and thoroughness of investigations that occurred that week. Persons Responsible: Program Coordinator, Program Director (QIDP), Area Director	

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	The PC indicated she was unable to access the clients' savings accounts using the computer. The PC indicated since she took over as the home manager, she had not received the clients' quarterly statements from the clients' bank. The PC indicated she had not reconciled the clients' savings accounts since June 2015. The PC indicated no one at the group home had reconciled the clients' savings accounts since June 2015. The PC indicated she was able to make deposits and withdrawals from the clients' accounts. The PC indicated when a deposit or withdrawal was made, she obtained a receipt with the balance of the clients' accounts. On 1/19/16 at 12:57 PM, the Program Director (PD) indicated the PC was supposed to receive quarterly statements from the bank to reconcile the clients' accounts. The PD indicated the PC was unable to get the clients' account information from the bank due to not being on the clients' accounts. The PD indicated the Area Director and his Administrative Assistant sent the banks letters to correct the situation however the PC was still not on the clients' accounts and not receiving statements. The PD indicated the bank was requesting a Corporate Resolution Letter from the facility. The PD indicated no			

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	one at the facility knew what a Corporate Resolution Letter was and what information the bank was requesting. The PD indicated the facility was not sure what to do to resolve the situation. The PD indicated the clients could withdrawal or deposit money into their accounts. The PD indicated the PC was unable to withdrawal or deposit money into the clients' accounts without the clients being present with her. The PD indicated the facility needed to reconcile the clients' savings accounts on a regular basis. The PD indicated no one at the facility had access to the clients' accounts. When asked what the facility was going to do to resolve the situation, the PD stated, "That's a good question." 2) Please refer to W149. For 12 of 49 incident/investigative reports reviewed affecting clients #1, #3 and #4, the governing body neglected to implement its policies and procedures to prevent client to client abuse, report an incident of possible financial exploitation to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner for client #3, report an incident of possible financial exploitation to BDDS for an incident of possible exploitation to BDDS for client #4, initiate an investigation of client #3 and #4's missing money discovered during the			

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	survey, ensure there was sufficient staff to implement client #1's Behavioral Support Plan, ensure client #1's plan indicated staff was to supervise her in person when she went out to smoke, conduct thorough investigations and take appropriate corrective actions to address client #1's elopement from the facility-operated day program. 3) Please refer to W153. For 2 of 49 incident reports reviewed affecting clients #3 and #4, the governing body failed to ensure incident reports for allegations of financial exploitation were submitted to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law. 4) Please refer to W154. For 8 of 49 incident/investigative reports reviewed affecting clients #1 and #4, the governing body failed to conduct thorough investigations. 5) Please refer to W157. For 2 of 49 incident/investigative reports reviewed affecting client #1, the governing body failed to ensure appropriate corrective actions were taken following incidents of elopement from the facility-operated day program.			

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	7) Please refer to W159. For 4 of 4 clients in the sample (#1, #3, #4 and #7) and 4 additional clients (#2, #5, #6 and #8), the governing body failed to ensure the Qualified Intellectual Disabilities Professional (QIDP) integrated, coordinated and monitored the clients' program plans. The governing body failed to ensure the clients' training objectives were expressed in measurable indices of performance. The governing body failed to ensure client #1's program plans were updated/revised to reflect, starting on 12/1/15, client #1's guardian approved she could smoke cigarettes. Client #1's program plans did not indicate client #1 needed restricted access to a lighter. Client #1's program plans did not indicate the staff was to be outside with her while she smoked due to elopement. The governing body failed to update and revise the clients' program plan criteria when the clients achieved or failed to achieve their criteria for completion. The governing body failed to ensure there was sufficient staff at the group home and facility-operated day program to prevent client #1 from eloping. The governing body failed to ensure the overnight evacuation drills were conducted at varied times. The governing body failed to ensure clients #4, #5 and #6 participated in meal preparation and serving themselves. The governing body			

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	failed to ensure the clients' finances were accounted for and there was a system in place to reconcile the clients' savings accounts. 9) Please refer to W186. For 8 of 8 clients living at the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the governing body failed to ensure there was sufficient staff to manage and supervise the clients in accordance with their individual program plans. 10) Please refer to W240. For 1 of 4 clients in the sample (#1), the governing body failed to ensure client #1's program plan was updated/revised to indicate the staff was to provide direct supervision while client #1 smoked and client #1 was to return her lighter to staff after she lit her cigarette. 9-3-1(a)			
W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review for 8 of 8 clients living in the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to meet the Condition of Participation: Client	W 0122	Staff in the home will be retrained on preventing client to client abuse. Observations will be completed by supervisory staff at least three times per week to ensure staff are following the	02/19/2016

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	Protections. The facility neglected to implement its policies and procedures to prevent client to client abuse, report an incident of possible financial exploitation to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner for client #3, report an incident of possible financial exploitation to BDDS for client #4, initiate an investigation of client #3 and #4's missing money discovered during the survey, ensure there was sufficient staff to implement client #1's Behavioral Support Plan, ensure client #1's plan indicated staff was to supervise her in person when she went out to smoke, conduct thorough investigations and take appropriate corrective actions to address client #1's elopement from the facility-operated day program. Findings include: 1) Please refer to W149. For 12 of 49 incident/investigative reports reviewed affecting clients #1, #3 and #4, the facility neglected to implement its policies and procedures to prevent client to client abuse, report an incident of possible financial exploitation to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner for client #3, report an incident of possible financial exploitation to BDDS for client		clients plans to prevent client to client abuse. Savings account records have been obtained for all clients and accounts have all been reconciled and are accurate. The Program Coordinator (HM) was retrained on the process for obtaining the savings account records for clients monthly, reconciling home accounts at least three times per week for each client, and setting up a more accountable system for client monies sent to the day program each month. The Program Director will review savings account records at least monthly to ensure accuracy and will address discrepancies appropriately. The PD (QIDP) was retrained on Incident Reporting and Investigation Completion and Thoroughness and completing recommended corrective actions. The Area Director will review investigations with the Program Director weekly to ensure completion and thoroughness of investigations that occurred that week. Staffing schedules in the home have been updated to ensure there are sufficient staff at all times to prevent client #1 from eloping. The PD monitors the schedules weekly to ensure sufficient staff are on duty and staff in the home have been trained to contact a supervisor immediately if there are problems with sufficient staff when they are	

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	#4, initiate an investigation of client #3 and #4's missing money discovered during the survey, ensure there was sufficient staff to implement client #1's Behavioral Support Plan, ensure client #1's plan indicated staff was to supervise her in person when she went out to smoke, conduct thorough investigations and take appropriate corrective actions to address client #1's elopement from the facility-operated day program. 2) Please refer to W153. For 2 of 49 incident reports reviewed affecting clients #3 and #4, the facility failed to submit incident reports for allegations of financial exploitation to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law. 3) Please refer to W154. For 8 of 49 incident/investigative reports reviewed affecting clients #1 and #4, the facility failed to conduct thorough investigations. 4) Please refer to W157. For 2 of 49 incident/investigative reports reviewed affecting client #1, the facility failed to ensure appropriate corrective actions were taken following incidents of elopement from the facility-operated day program.		on duty. Client #1's Behavior Support Plan has been updated including the changes approved by guardian and staff have been trained on the updated plan both in the home and at the day program. Persons Responsible: Program Coordinator, Program Director (QIDP), Area Director	

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	5) Please refer to W186. For 8 of 8 clients living at the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to ensure there was sufficient staff to manage and supervise the clients in accordance with their individual program plans. 9-3-2(a)			
W 0125 Bldg. 00	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, interview and record review for 1 of 4 clients in the sample (#1), the facility failed to ensure client #1 had the right to due process in regard to restricting her access to a lighter. Findings include: On 1/12/16 from 3:48 PM to 5:55 PM, an observation was conducted at the group home. At 4:14 PM, client #1 was given a lighter and a cigarette. Client #1 went outside to smoke the cigarette. At 5:02 PM when client #1 requested a cigarette,	W 0125	Client #1's Behavior Support Plan has been updated including the changes approved by guardian and staff have been trained on the updated plan both in the home and at the day program. No other clients were affected by this deficient practice. The Program Director (QIDP) will meet with the Behavior Analyst monthly to review Behavior Support Plans to ensure any changes are included in the plans and the plans are updated.Person Responsible: Program Director (QIDP)	02/19/2016

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	client #1 told the Program Coordinator (PC) she had the lighter in her pocket from earlier. The PC indicated to client #1 she was supposed to return the lighter to staff when she was finished smoking. Client #1 indicated she forgot to give the lighter to staff. On 1/13/16 at 12:46 PM, a review of client #1's record was conducted. There was no documentation in client #1's 8/4/15 Individualized Support Plan (ISP) and 11/9/15 Behavioral Support Plan (BSP) of the need for restricted access to a lighter. There was no plan addressing restricted access to a lighter. On 1/13/16 at 1:17 PM, a review of an email sent from the Behavior Consultant to the Program Director (PD) indicated, "...It was determined that [client #1] will not have access to her lighter all the times (sic), it will be kept with her cigarettes and she will only have access to it when she is given a cigarette...." On 1/19/16 at 1:01 PM, the PD stated it was "common sense" that client #1 did not have access to a lighter. The PD indicated the restriction was not part of a plan. The PD indicated at the request from the guardian, client #1 was to have access to a lighter when she lit her cigarette. The PD indicated client #1 was			

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	supposed to give the lighter back to the staff immediately after lighting her cigarette. The PD indicated client #1 did not have a history of setting fires and did not hurt herself or others with the lighter. The PD indicated client #1's restriction to access her lighter needed to be included in a plan. On 1/19/16 at 1:50 PM, the Behavior Consultant (BC) indicated she was told by the PD that the PD was going to add client #1's restricted access to her lighter to the ISP. The BC indicated she did not add the restriction to the BSP since she was told it was going to be added to the ISP. The BC indicated the restriction was added when client #1 started smoking again. The BC indicated it was discussed the lighter would be kept locked up with client #1's cigarettes. 9-3-2(a)			
W 0140 Bldg. 00	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds			

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	entrusted to the facility on behalf of clients. Based on record review and interview for 2 of 4 clients in the sample (#3 and #4), the facility failed to keep a full and complete accounting of the clients' personal funds. Findings include: On 1/12/16 at 4:21 PM when the surveyor and the Program Coordinator (PC) counted the clients' finances for the survey, client #3's January 2016 Cash on Hand ledger indicated she had $33.52. When the PC counted client #3's money, client #3 had $23.52. There was no documentation accounting for the missing $10.00. There was no documentation of $10.00 being removed from the client's finances. There were no receipts for the $10.00. On 1/12/16 at 4:21 PM, the PC indicated she did not know where client #3's $10.00 was spent or why the money was withdrawn from her account. The PC indicated there was no documentation accounting for the missing $10.00. The PC indicated one of the staff may have taken the money out to give to client #3 however there was no documentation this occurred. The PC indicated the facility should account for the client's funds to the penny.	W 0140	Savings account records have been obtained for all clients and accounts have all been reconciled and are accurate. The Program Coordinator (HM) was retrained on the process for obtaining the savings account records for clients monthly, reconciling home accounts at least three times per week for each client, and setting up a more accountable system for client monies sent to the day program each month. The Program Director will review savings account records at least weekly to ensure accuracy and will address discrepancies appropriately.Persons Responsible: Program Coordinator, Program Director (QIDP)	02/19/2016

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	2) On 1/12/16 at 4:21 PM when the surveyor and the PC counted the client's finances for the survey, client #4's January 2016 Cash on Hand ledger indicated she had $17.49. When the PC counted client #4's money, client #4 had $15.86. There was no documentation accounting for the missing $1.63. There was no documentation of $1.63 being removed from the client's finances. There were no receipts for the $1.63. On 1/12/16 at 4:21 PM, the PC indicated she did not know where client #4's $1.63 was spent or why the money was withdrawn from her account. The PC indicated there was no documentation accounting for the missing $1.63. The PC indicated one of the staff may have taken the money out to give to client #4 however there was no documentation this occurred. The PC indicated the facility should account for the client's funds to the penny. 9-3-2(a)			
W 0149 Bldg. 00	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.			

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	Based on observation, interview and record review for 12 of 49 incident/investigative reports reviewed affecting clients #1, #3 and #4, the facility neglected to implement its policies and procedures to prevent client to client abuse, report an incident of possible financial exploitation to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner for client #3, report an incident to BDDS for an incident of possible financial exploitation for client #4, initiate an investigation of client #3 and #4's missing money discovered during the survey, ensure there was sufficient staff to implement client #1's Behavioral Support Plan, ensure client #1's plan indicated staff was to supervise her in person when she went out to smoke, conduct thorough investigations and take appropriate corrective actions to address client #1's elopement from the facility-operated day program. Findings include: 1) An observation was conducted at the group home on 1/12/16 from 3:48 PM to 5:55 PM. On 1/12/16 at 4:21 PM when the surveyor and the Program Coordinator (PC) counted the client's finances for the survey, client #3's January 2016 Cash on Hand ledger	W 0149	Staff in the home will be retrained on preventing client to client abuse. Observations will be completed by supervisory staff at least three times per week to ensure staff are following the clients plans to prevent client to client abuse. The PD (QIDP) was retrained on Incident Reporting and Investigation Completion and Thoroughness and completing recommended corrective actions. The Area Director will review investigations with the Program Director weekly to ensure completion and thoroughness of investigations that occurred that week. Staffing schedules in the home have been updated to ensure there are sufficient staff at all times to prevent client #1 from eloping. The PD monitors the schedules weekly to ensure sufficient staff are on duty and staff in the home have been trained to contact a supervisor immediately if there are problems with sufficient staff when they are on duty. Client #1's Behavior Support Plan has been updated including the changes approved by guardian and staff have been trained on the updated plan both in the home and at the day program. Persons Responsible: Program Coordinator, Program Director (QIDP), Area Director	02/19/2016

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	indicated she had $33.52. When the PC counted client #3's money, client #3 had $23.52. There was no documentation accounting for the missing $10.00. There was no documentation of $10.00 being removed from the client's finances. There were no receipts for the $10.00. On 1/14/16 at 4:05 PM, a review of a 1/14/16 BDDS report for client #3 indicated, "During the annual survey and while counting client finances, one client's money was $10.00 off from the statement. An investigation will be conducted to determine the reason for missing finances." The facility failed to submit the BDDS report in a timely manner. On 1/12/16 at 4:21 PM, the PC indicated she did not know where client #3's $10.00 was spent or why the money was withdrawn from her account. The PC indicated there was no documentation accounting for the missing $10.00. The PC indicated one of the staff may have taken the money out to give to client #3 however there was no documentation this occurred. On 1/14/16 at 12:19 PM, the Program Director (PD) indicated the facility did not find the client's missing money. The PD indicated client #3's missing money			

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	was not reported to BDDS and an investigation had not been initiated. The PD indicated the PC informed her of the missing money on 1/12/16 when the PD arrived to the group home. The PD indicated she informed the Area Director (AD) on 1/12/16 at approximately 6:30 PM to 7:00 PM. The PD indicated client #3's $10.00 was still missing and not accounted for. 2) An observation was conducted at the group home on 1/12/16 from 3:48 PM to 5:55 PM. On 1/12/16 at 4:21 PM when the surveyor and the PC counted the client's finances for the survey, client #4's January 2016 Cash on Hand ledger indicated she had $17.49. When the PC counted client #4's money, client #4 had $15.86. There was no documentation accounting for the missing $1.63. There was no documentation of $1.63 being removed from the client's finances. There were no receipts for the $1.63. There was no documentation the facility submitted a BDDS report for client #4's missing money. On 1/12/16 at 4:21 PM, the PC indicated she did not know where client #4's $1.63 was spent or why the money was withdrawn from her account. The PC indicated there was no documentation			

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	accounting for the missing $1.63. The PC indicated one of the staff may have taken the money out to give to client #4 however there was no documentation this occurred. On 1/15/16 at 12:29 PM, the PD stated when asked if she submitted a BDDS report for client #4's missing money, "No, I didn't even know." The PD indicated was not aware client #4 was missing money from her account. The PD indicated she did not submit a BDDS report since she was not informed of the issue. 3) On 1/12/16 at 12:38 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 11/8/15 at 6:30 PM, client #1 eloped from the home without staff's knowledge. The police were contacted and found her. Client #1 made threats of self-harm and the police took her to the hospital for an evaluation. The 11/11/15 Investigation Summary indicated, in part, "[Staff #8] inquired as to where [client #1] was by asking [staff #1] and [staff #1] reported that [client #1] was outside on the back porch." The investigation indicated, "... [Staff #8] stated that he asked [staff #1] where [client #1] was. [Staff #8] stated			

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	that [staff #1] said she had just checked on her outside and she was fine. [Staff #8] said he went to check on her because he 'had a feeling she left' so he went outside and looked for her and couldn't find her so he got in his car and drove around and looked for her for about 10-15 minutes and couldn't find her so he called the police for help. [Staff #8] said it had been about 2-3 minutes since [staff #1] said she had seen [client #1] before he asked about her and then started looking for her...." Client #1 was located about a mile from the house. The investigation indicated, "[Client #1] stated that [staff #1] had come out to check on her and when [staff #1] went back into the house, she walked away... She stated that after dinner, she took her e-cigarette outside on the back deck to smoke but she wanted real cigarettes...." The Conclusion of the investigation indicated, "Evidence supports staff intervened appropriately. Evidence supports staff implemented BSP appropriately." The Recommendations section indicated, "Continue to follow BSP and update as needed. Will discuss with team if changes are needed to supervision level in the home while in common areas or while outside smoking." On 1/13/16 at 12:46 PM, a review of			

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	client #1's 9/30/14 BSP indicated in the absent without notification or permission section, "Follow [client #1] either in vehicle or on foot to maintain line of sight and to maintain level of safety." The facility failed to conduct a thorough investigation. Client #1 had a plan to address elopement. The plan indicated she was to be in line of sight to maintain a level of safety when she eloped. The staff failed to implement the plan as written. The facility failed to identify in the investigation the staff failed to implement client #1's plan as written. On 1/12/16 at 1:11 PM, the AD indicated staff should have been outside with her. On 1/12/16 at 2:24 PM, the PD indicated following the incident, a review of the BSP revealed the BSP did not say staff were to keep her in line of sight when she went out to smoke. The PD indicated the plan included that the staff was to maintain eyesight to prevent harm when she eloped. On 1/15/16 at 12:29 PM, the PD indicated the staff did not intervene appropriately. The PD indicated the staff should have been outside with her at the time of the incident. The PD indicated the staff followed the plan after they discovered she was missing. The PD indicated at the time of the incident,			

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	client #1 did not have a plan to have staff with her while she smoked even though there were door alarms on all exit doors due to client #1's elopement. The PD stated she "assumed" the staff was going out with her. The PD indicated line of sight supervision was added to client #1's plan following the incident. 4) On 10/30/15 at 9:30 PM, the 10/31/15 BDDS report indicated, "[Client #1] returned home from (a) Halloween dance and became upset when another client began having a behavior. [Client #1] walked out the front door and up the road. Since there was only 1 staff on duty, the police were called, per policy, because the rest of the clients could not be left alone. The police intercepted [client #1] a few blocks up the road and brought her back to the house...." The 11/2/15 Investigation Summary indicated, in part, "[Staff #8] was the only staff (sic) that time prior to other shift coming in and when [client #1] eloped, he followed BSP and called the police since he could not leave other clients unattended...." The interview with staff #8 indicated, in part, "[Staff #8] mentioned he called the Program Director and was told to call the police since he was the only one on duty. [Staff #8] said I didn't know what else to do, so			

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	I was just doing what I was told...." The Conclusion of the investigation indicated, "Evidence supports staff implemented BSP appropriately." The Recommendations section indicated, "Program Director met with Program Coordinator and put into place that 2 people must be on site at all times when [client #1] is present. For elopement purposes, 2 staff should be present so that one can follow her, and one can stay with other clients. PC know (sic) that if any time there is a time lapse, PC is to find coverage or cover it herself." On 1/15/16 at 8:51 AM, the PC indicated staff #8 left the party early without notifying her. The PC indicated she was going to meet him at the party to ensure there were two staff on the van during transport on the way back to the group home and two staff at the house once they arrived. The facility failed to conduct a thorough investigation. The investigation did not include an interview with the PC. The facility failed to indicate staff #8 did not follow protocol and notify his supervisor when he was working alone. On 1/12/16 at 1:38 PM, a 9/14/15 Staff Training form indicated, "Staff need to call supervisor with questions with			

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	scheduling. Call immediate supervisor during regular business hours and on-call PC after hours and on weekends. If you are scheduled alone, please report this immediately. Due to client behavior support plans, we cannot fully adhere to the guidelines explained if we have insufficient staffing while at work...." On 1/14/16 at 3:37 PM, the PD indicated the incident occurred due to a miscommunication between the day program staff and the group home staff. The PD stated regarding there being one staff working at the time, "I questioned it as well." The PD indicated staff #8 and another staff were supposed to go to the house. The PD indicated staff #8 should have reported to the PC he was working alone, as previously instructed. The PD indicated staff #8 did not report he was working alone until after client #1 eloped. The PD indicated staff #8 reported the incident to her and indicated he was working alone. The PD indicated staff #8 reported he did not know why he was working alone. The PD indicated the PC told her there was another staff from the party who was supposed to ride with the clients and staff #8 to the group home but this did not occur. The PD indicated this information should have been included in the investigation.			

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	5) On 10/5/15 at 3:00 PM, client #4 slapped client #1 as they were getting out of the van. Client #1 was not injured. The 10/6/15 BDDS report indicated, "It is unknown why [client #4] was upset but appeared to calm after a few minutes." There was no documentation the facility conducted an investigation. On 1/14/16 at 3:37 PM, the PD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The PD indicated the facility had a policy and procedure prohibiting abuse of the clients. On 1/15/16 at 12:29 PM, the PD indicated the facility should conduct investigations of client to client abuse. 6) On 10/1/15 at 5:40 PM, the 10/6/15 Investigation Summary indicated, "Brief Summary of Incident: [Client #1] was told she could not go on outing due to previous elopement that day. [Client #1] was screaming, stomping, and throwing things in her room. She then began pulling her hair, hitting herself in the head with a cup and fists. [Staff #9] tried to verbally redirect [client #1] to stop. [Client #1] continued to hit herself with force. Staff used blocking techniques to try and prevent her from hitting herself. [Client #1] then began attempting to hit,			

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	kick and head butt staff. Staff then used open hand PIA (Physical Intervention Alternatives) hold to her arms for about 20 seconds, to prevent [client #1] from continuing to hit herself in the head. [Client #1] stopped hitting herself after this." The report indicated, "Staff tried to talk to [client #1] and calm her down, but [client #1] refused to listen and became more upset due to not going on an outing...." The interview with staff #9 indicated, "[Staff #9] stated that [client #1] was upset that she wanted to go and get batteries and when [Program Coordinator] said they couldn't go that minute, [client #1] started yelling and stomping around the kitchen and went into her bedroom...." The interview with the PC indicated, "When asked what happened that night, [PC] stated that they were just finishing up with dinner, and [client #1] asked me to go to [name of store] and I (sic) her that maybe we could in a little bit, we have other things to do first...." The Conclusion of the investigation indicated, "Evidence supports staff intervened appropriately." The investigation indicated client #1's BSP was reviewed however there was no documentation in the investigation addressing the conflicting information regarding client #1 being told she could not go on an outing due to eloping earlier			

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	in the day. On 1/13/16 at 12:46 PM, a review of client #1's 9/30/14 BSP indicated there was no plan for client #1 to lose an outing if she eloped. The plan indicated, "Guardian may instruct staff to cancel an activity or delay access to personal property (due to) resistance to instruction when trying to calm down from threatening behavior. Clear guidelines should be given if an activity or property can be earned back after complying with calming down, taking a break or requesting help appropriately." On 1/12/16 at 1:09 PM, the Area Director (AD) indicated the investigation did not make sense to him. The AD indicated the PD may have forgot to erase the Summary from another investigation. The AD indicated he requested the PD to re-do the investigation. The AD indicated he did not have documentation the PD revised or updated the investigation. The AD indicated the investigation should have been revised or more information added to resolve the conflicting information. The AD indicated there was nothing in client #1's plan indicating she would lose an outing when she eloped. The AD stated this was "not part of the plan."			

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	On 1/12/16 at 2:39 PM, the PD indicated she was not sure if losing an outing was part of client #1's plan or not. The PD stated, "For them to say it it needs to be part of the plan." On 1/15/16 at 12:29 PM, the PD indicated she was not requested to revise or provide additional information for the investigation. The PD indicated she obtained the information documented in the brief summary from the initial report from the staff of the incident. The PD indicated the conflicting information in the investigation should have been addressed and resolved in the investigation. 7) On 9/30/15 at 2:04 PM, client #1 eloped from the facility-operated day program. The 10/5/15 Investigation Summary indicated, "Staff was by herself with 3 clients and called an employee of TSI and she was there within minutes. [Client #1] made it down the road to [name of gas station] and staff got her into the car and brought her back to day program." Client #1's interview in the investigation indicated, "...I wanted to smoke and [name of day program staff #1] would not let me go outside. I can smoke if I want to. She couldn't leave because there were other clients here...." Day program staff #1's interview in the investigation indicated, "[Client #1] wanted to go outside. When I explained			

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	that we were doing an activity and that when the other staff get (sic) back then I would go out with her. She got mad and walked out the front door. There were 3 other clients in the building so I could not leave...." The Conclusion of the investigation indicated, "Evidence supports staff intervened appropriately." The Recommendations section indicated, "Staff will continue to follow BSP, policy and procedures to ensure [client #1's] safety." The investigation was not thorough. The investigation did not address there was insufficient amount of staff at the time of the incident to implement client #1's BSP. There was no documentation of corrective action to ensure there was sufficient staff at the facility-operated day program. On 1/13/16 at 12:46 PM, a review of client #1's 9/30/14 BSP indicated in the absent without notification or permission section, "Follow [client #1] either in vehicle or on foot to maintain line of sight and to maintain level of safety." On 1/14/16 at 3:37 PM, the PD indicated she was unsure what the staffing level at the facility-operated day program was supposed to be. The PD indicated she instructed the day program to ensure			

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	there were at least two staff present when client #1 attended the day program to ensure there was sufficient staff to implement her plan. On 1/15/16 at 12:29 PM, the PD indicated the investigation should have addressed there was insufficient staff at the time of the incident. The PD indicated the investigation should have included documentation of corrective action taken to address the staffing level at the day program. On 1/13/16 at 8:48 AM, the Day Program Program Director (DPPD) indicated client #1 had not eloped from the day program in the past 12 months without staff following her. The DPPD indicated the day program staff monitor client #1 from inside the building when she smokes. The DPPD indicated the day program staff did not go outside to monitor client #1's whereabouts. 8) On 9/12/15 at 3:15 PM, client #1 told staff she was going to lie down to take a nap. While staff was assisting other clients with making dinner client #1 went out the back door and eloped. While staff was conducting checks approximately 10 minutes later, staff noticed client #1 was not in her room. Staff looked out the front door and observed client #1 walking up the street			

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	and out of line of sight. Staff called the police and the police returned her to the home. Client #1 indicated she was on her way to a store to find cigarettes. The 9/14/15 Investigation Summary indicated in the Factual Findings section, "Staff [#8] was working at [name of group home] alone from after day program (4:00 PM) until 6 PM when 2 staff was (sic) to come in. Within minutes of noticing that [client #1] was not in her bedroom, she was noticed walking up the street. Unable to follow her, [staff #8] called the police and policed (sic) picked her up on the road and returned her to the group home. Staff was asked why he was working alone, he mentioned he was OK with working alone for the 2 hours until the second staff got there. PD did a record of discussion of Program Coordinator explaining importance of sufficient staffing. PD also did a staff training on 9/14/15 to let staff know that if they are ever alone while at work, to call immediate supervisor and if after hours, to call on-call and report staffing issue." The Conclusion of the investigation indicated, "Evidence supports staff implemented BSP appropriately." On 1/15/16 at 11:39 AM, a communication from the Program Coordinator to the group home staff			

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	indicated, "While I was out on vacation [PD] held a meeting on 9-14-15. This meeting was over what staff should do if they are left alone with [client #1], because of recent elopements from [client #1]. There is to be always two staff on shift. If for some reason an error in the schedule or a no call no show staff should notify myself or [PD] immediately... This starts immediately." On 1/12/16 at 1:38 PM, a 9/14/15 Record of Discussion was given to the PC due to a staff being by herself during a client elopement. The staff was unable to implement the client's BSP due to insufficient staffing at the home. The Action being taken section indicated, "Training to staff, BSP training, reportable incident trainings and on-call procedures for insufficient staffing." On 1/14/16 at 3:37 PM, the PD indicated the group home should have at least two staff during waking hours to implement the clients' program plans. The PD indicated with one staff, client #1's program plan could not be implemented as written. 9) On 6/29/15 at 7:15 PM, client #4 wanted to use the house phone. Client #1 was on the phone. When client #1 would not give client #4 the phone, client #4 hit			

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	client #1. Client #1 hit client #4. Client #4 threw her headphones and started screaming. Client #1 shoved a wheelchair into the wall. There was no documentation the facility conducted an investigation. On 1/14/16 at 3:37 PM, the PD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The PD indicated the facility had a policy and procedure prohibiting abuse of the clients. On 1/15/16 at 12:29 PM, the PD indicated the facility should conduct investigations of client to client abuse. 10) On 5/11/15 at 4:30 PM while riding in the group home van, client #4 was upset the van stopped at another group home. Client #4 scraped client #1's arm requiring first aid. Client #1 slapped client #4 on the arm. There was no documentation the facility conducted an investigation. On 1/14/16 at 3:37 PM, the PD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The PD indicated the facility had a policy and procedure prohibiting abuse of the clients. On			

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	1/15/16 at 12:29 PM, the PD indicated the facility should conduct investigations of client to client abuse. 11) On 4/8/15 at 6:30 PM, client #1 was upset when she was picked up at the facility-operated day program. Upon arrival to the group home, staff heard client #1 yelling. Staff went to client #1's bedroom and observed client #1 take an object and stab herself twice on the forearm. Client #1 dropped the object. Staff applied pressure to stop the bleeding and called for an ambulance. Client #1 was taken to the emergency room and received four stitches. The 4/9/15 BDDS report indicated, "Follow up instructions were to follow up with [name of counseling center] for group and individual therapy and to keep sharp objects out of reach." There was no documentation the facility conducted an investigation. On 1/15/16 at 12:29 PM, the PD indicated she was not instructed to conduct an investigation. The PD indicated there was no corrective action taken. The PD indicated client #1 used a pair of scissors to stab herself that she obtained from the office area of the group home. The PD stated, "Someone failed to lock up the sharps." The PD indicated			

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	at the time of the incident the sharps in the home were to be locked up. On 1/13/16 at 1:35 PM, the Area Director (AD) indicated the facility did not conduct an investigation. The AD stated he "didn't see a need for an investigation." The AD indicated the staff was not negligent. The AD stated it was "evident that staff was not negligent." The AD stated, "with the knowledge we had it was evident what happened." 12) On 3/18/15 at 9:50 AM at the facility-operated day program, client #1 was sitting in the program room. When the staff was occupied with another client, client #1 snuck out the front door and started walking toward the gas station. Client #1 indicated she went to the gas station to pick up cigarette butts to smoke. Client #1 was observed by a staff going to the day program. The staff called the day program and client #1 was transported back to the day program. Client #1's interview in the 3/19/15 Investigation Summary indicated, "...I was looking for cigarette butts to smoke. I want to smoke but everybody says that I can't... PD asked [client #1] if she knew that smoking other peoples (sic) cigarette butts could make her sick, [client #1] stated, 'I don't care. I have done it before			

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	and not got sick.'" The Conclusion of the investigation indicated, "Evidence supports staff intervened appropriately." There was no documentation of corrective action taken following the incident in the Investigation Summary. The corrective action section was blank. On 1/15/16 at 12:29 PM, the PD indicated the facility should have implemented corrective action following the incident. The facility's policy and procedures related to abuse and neglect were reviewed on 1/15/16 at 11:25 AM. The facility's Quality and Risk Management policy dated April 2011 indicated, "Indiana MENTOR promotes a high quality of service and seeks to protect individuals receiving Indiana MENTOR services through oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed." The policy defined neglect as, "e. Failure to provide appropriate supervision, care or training; f. Failure to provide a safe, clean and sanitary environment...." The Human Rights policy, dated April 2011, indicated, in part, "The following actions			

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	are prohibited by employees of Indiana MENTOR: abuse, neglect, exploitation or mistreatment of an individual including misuse of an individual's funds; or violation of an individual's rights." The policy indicated, in part, "Indiana MENTOR programs maintain a written list of rights, which take into account the requirements of applicable laws, regulations, and purchasing agencies. This list of rights should include, but is not limited to: e. Ensure the clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment." 9-3-2(a)			
W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 2 of 49 incident reports reviewed affecting clients #3 and #4, the facility failed to submit incident reports to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.	W 0153	The PD (QIDP) was retrained on Incident Reporting and Investigation Completion and Thoroughness and completing recommended corrective actions. The Area Director will review investigations with the Program Director weekly to ensure completion and thoroughness of investigations that occurred that	02/19/2016

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	Findings include: 1) An observation was conducted at the group home on 1/12/16 from 3:48 PM to 5:55 PM. On 1/12/16 at 4:21 PM when the surveyor and the Program Coordinator (PC) counted the clients' finances for the survey, client #3's January 2016 Cash on Hand ledger indicated she had $33.52. When the PC counted client #3's money, client #3 had $23.52. There was no documentation accounting for the missing $10.00. There was no documentation of $10.00 being removed from the client's finances. There were no receipts for the $10.00. On 1/14/16 at 4:05 PM, a review of a 1/14/16 BDDS report for client #3 indicated, "During the annual survey and while counting client finances, one client's money was $10.00 off from the statement. An investigation will be conducted to determine the reason for missing finances." The facility failed to submit the BDDS report in a timely manner. On 1/14/16 at 12:19 PM, the Program Director (PD) indicated the facility did not find the client's missing money. The PD indicated client #3's missing money was not reported to BDDS.		week. Persons Responsible: Program Director (QIDP), Area Director	

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	2) An observation was conducted at the group home on 1/12/16 from 3:48 PM to 5:55 PM. On 1/12/16 at 4:21 PM when the surveyor and the PC counted the clients' finances for the survey, client #4's January 2016 Cash on Hand ledger indicated she had $17.49. When the PC counted client #4's money, client #4 had $15.86. There was no documentation accounting for the missing $1.63. There was no documentation of $1.63 being removed from the client's finances. There were no receipts for the $1.63. There was no documentation the facility submitted a BDDS report for client #4's missing money. On 1/15/16 at 12:29 PM, the PD stated when asked if she submitted a BDDS report for client #4's missing money, "No, I didn't even know." The PD indicated was not aware client #4 was missing money from her account. The PD indicated she did not submit a BDDS report since she was not informed of the issue. 9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all			

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	alleged violations are thoroughly investigated. Based on record review and interview for 8 of 49 incident/investigative reports reviewed affecting clients #1 and #4, the facility failed to conduct thorough investigations. Findings include: On 1/12/16 at 12:38 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 11/8/15 at 6:30 PM, client #1 eloped from the home without staff's knowledge. The police were contacted and found her. Client #1 made threats of self-harm and the police took her to the hospital for an evaluation. The 11/11/15 Investigation Summary indicated, in part, "[Staff #8] inquired as to where [client #1] was by asking [staff #1] and [staff #1] reported that [client #1] was outside on the back porch." The investigation indicated, "...[Staff #8] stated that he asked [staff #1] where [client #1] was. [Staff #8] stated that [staff #1] said she had just checked on her outside and she was fine. [Staff #8] said he went to check on her because he 'had a feeling she left' so he went outside and looked for her and couldn't find her so he got in	W 0154	The PD (QIDP) was retrained on Incident Reporting and Investigation Completion and Thoroughness and completing recommended corrective actions. The Area Director will review investigations with the Program Director weekly to ensure completion and thoroughness of investigations that occurred that week. Persons Responsible: Program Director (QIDP), Area Director	02/19/2016

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	his car and drove around and looked for her for about 10-15 minutes and couldn't find her so he called the police for help. [Staff #8] said it had been about 2-3 minutes since [staff #1] said she had seen [client #1] before he asked about her and then started looking for her...." Client #1 was located about a mile from the house. The investigation indicated, "[Client #1] stated that [staff #1] had come out to check on her and when [staff #1] went back into the house, she walked away... She stated that after dinner, she took her e-cigarette outside on the back deck to smoke but she wanted real cigarettes...." The Conclusion of the investigation indicated, "Evidence supports staff intervened appropriately. Evidence supports staff implemented BSP appropriately." The Recommendations section indicated, "Continue to follow BSP and update as needed. Will discuss with team if changes are needed to supervision level in the home while in common areas or while outside smoking." On 1/13/16 at 12:46 PM, a review of client #1's 9/30/14 BSP indicated in the absent without notification or permission section, "Follow [client #1] either in vehicle or on foot to maintain line of sight and to maintain level of safety."			

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	The facility failed to conduct a thorough investigation. Client #1 had a plan to address elopement. The plan indicated she was to be in line of sight to maintain a level of safety when she eloped. The staff failed to implement the plan as written. The facility failed to identify in the investigation the staff failed to implement client #1's plan as written. On 1/12/16 at 1:11 PM, the AD indicated staff should have been outside with her. On 1/12/16 at 2:24 PM, the PD indicated following the incident, a review of the BSP revealed the BSP did not say staff were to keep her in line of sight when she went out to smoke. The PD indicated the plan included that the staff was to maintain eyesight to prevent harm when she eloped. On 1/15/16 at 12:29 PM, the PD indicated the staff did not intervene appropriately. The PD indicated the staff should have been outside with her at the time of the incident. The PD indicated the staff followed the plan after they discovered she was missing. The PD indicated at the time of the incident, client #1 did not have a plan to have staff with her while she smoked even though there were door alarms on all exit doors due to client #1's elopement. The PD stated she "assumed" the staff was going out with her. The PD indicated line of			

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	sight supervision was added to client #1's plan following the incident. 2) On 10/30/15 at 9:30 PM, the 10/31/15 BDDS report indicated, "[Client #1] returned home from (a) Halloween dance and became upset when another client began having a behavior. [Client #1] walked out the front door and up the road. Since there was only 1 staff on duty, the police were called, per policy, because the rest of the clients could not be left alone. The police intercepted [client #1] a few blocks up the road and brought her back to the house...." The 11/2/15 Investigation Summary indicated, in part, "[Staff #8] was the only staff (sic) that time prior to other shift coming in and when [client #1] eloped, he followed BSP and called the police since he could not leave other clients unattended...." The interview with staff #8 indicated, in part, "[Staff #8] mentioned he called the Program Director and was told to call the police since he was the only one on duty. [Staff #8] said I didn't know what else to do, so I was just doing what I was told...." The Conclusion of the investigation indicated, "Evidence supports staff implemented BSP appropriately." The Recommendations section indicated, "Program Director met with Program			

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	Coordinator and put into place that 2 people must be on site at all times when [client #1] is present. For elopement purposes, 2 staff should be present so that one can follow her, and one can stay with other clients. PC know (sic) that if any time there is a time lapse, PC is to find coverage or cover it herself." On 1/15/16 at 8:51 AM, the PC indicated staff #8 left the party early without notifying her. The PC indicated she was going to meet him at the party to ensure there were two staff on the van during transport on the way back to the group home and two staff at the house once they arrived. The facility failed to conduct a thorough investigation. The investigation did not include an interview with the PC. The facility failed to indicate staff #8 did not follow protocol and notify his supervisor when he was working alone. On 1/12/16 at 1:38 PM, a 9/14/15 Staff Training form indicated, "Staff need to call supervisor with questions with scheduling. Call immediate supervisor during regular business hours and on-call PC after hours and on weekends. If you are scheduled alone, please report this immediately. Due to client behavior support plans, we cannot fully adhere to			

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	the guidelines explained if we have insufficient staffing while at work...." On 1/14/16 at 3:37 PM, the PD indicated the incident occurred due to a miscommunication between the day program staff and the group home staff. The PD stated regarding there being one staff working at the time, "I questioned it as well." The PD indicated staff #8 and another staff were supposed to go to the house. The PD indicated staff #8 should have reported to the PC he was working alone, as previously instructed. The PD indicated staff #8 did not report he was working alone until after client #1 eloped. The PD indicated staff #8 reported the incident to her and indicated he was working alone. The PD indicated staff #8 reported he did not know why he was working alone. The PD indicated the PC told her there was another staff from the party who was supposed to ride with the clients and staff #8 to the group home but this did not occur. The PD indicated this information should have been included in the investigation. 3) On 10/5/15 at 3:00 PM, client #4 slapped client #1 as they were getting out of the van. Client #1 was not injured. The 10/6/15 BDDS report indicated, "It is unknown why [client #4] was upset but appeared to calm after a few minutes."			

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	There was no documentation the facility conducted an investigation. On 1/14/16 at 3:37 PM, the PD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The PD indicated the facility had a policy and procedure prohibiting abuse of the clients. On 1/15/16 at 12:29 PM, the PD indicated the facility should conduct investigations of client to client abuse. 4) On 10/1/15 at 5:40 PM, the 10/6/15 Investigation Summary indicated, "Brief Summary of Incident: [Client #1] was told she could not go on outing due to previous elopement that day. [Client #1] was screaming, stomping, and throwing things in her room. She then began pulling her hair, hitting herself in the head with a cup and fists. [Staff #9] tried to verbally redirect [client #1] to stop. [Client #1] continued to hit herself with force. Staff used blocking techniques to try and prevent her from hitting herself. [Client #1] then began attempting to hit, kick and head butt staff. Staff then used open hand PIA (Physical Intervention Alternatives) hold to her arms for about 20 seconds, to prevent [client #1] from continuing to hit herself in the head. [Client #1] stopped hitting herself after			

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	this." The report indicated, "Staff tried to talk to [client #1] and calm her down, but [client #1] refused to listen and became more upset due to not going on an outing...." The interview with staff #9 indicated, "[Staff #9] stated that [client #1] was upset that she wanted to go and get batteries and when [Program Coordinator] said they couldn't go that minute, [client #1] started yelling and stomping around the kitchen and went into her bedroom...." The interview with the PC indicated, "When asked what happened that night, [PC] stated that they were just finishing up with dinner, and [client #1] asked me to go to [name of store] and I (sic) her that maybe we could in a little bit, we have other things to do first...." The Conclusion of the investigation indicated, "Evidence supports staff intervened appropriately." The investigation indicated client #1's BSP was reviewed however there was no documentation in the investigation addressing the conflicting information regarding client #1 being told she could not go on an outing due to eloping earlier in the day. On 1/13/16 at 12:46 PM, a review of client #1's 9/30/14 BSP indicated there was no plan for client #1 to lose an outing if she eloped. The plan indicated,			

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	"Guardian may instruct staff to cancel an activity or delay access to personal property (due to) resistance to instruction when trying to calm down from threatening behavior. Clear guidelines should be given if an activity or property can be earned back after complying with calming down, taking a break or requesting help appropriately." On 1/12/16 at 1:09 PM, the Area Director (AD) indicated the investigation did not make sense to him. The AD indicated the PD may have forgot to erase the Summary from another investigation. The AD indicated he requested the PD to re-do the investigation. The AD indicated he did not have documentation the PD revised or updated the investigation. The AD indicated the investigation should have been revised or more information added to resolve the conflicting information. The AD indicated there was nothing in client #1's plan indicating she would lose an outing when she eloped. The AD stated this was "not part of the plan." On 1/12/16 at 2:39 PM, the PD indicated she was not sure if losing an outing was part of client #1's plan or not. The PD stated, "For them to say it it needs to be part of the plan." On 1/15/16 at 12:29 PM, the PD indicated she was not			

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	requested to revise or provide additional information for the investigation. The PD indicated she obtained the information documented in the brief summary from the initial report from the staff of the incident. The PD indicated the conflicting information in the investigation should have been addressed and resolved in the investigation. 5) On 9/30/15 at 2:04 PM, client #1 eloped from the facility-operated day program. The 10/5/15 Investigation Summary indicated, "Staff was by herself with 3 clients and called an employee of TSI and she was there within minutes. [Client #1] made it down the road to [name of gas station] and staff got her into the car and brought her back to day program." Client #1's interview in the investigation indicated, "...I wanted to smoke and [name of day program staff #1] would not let me go outside. I can smoke if I want to. She couldn't leave because there were other clients here...." Day program staff #1's interview in the investigation indicated, "[Client #1] wanted to go outside. When I explained that we were doing an activity and that when the other staff get (sic) back then I would go out with her. She got mad and walked out the front door. There were 3 other clients in the building so I could not leave...." The Conclusion of the			

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	investigation indicated, "Evidence supports staff intervened appropriately." The Recommendations section indicated, "Staff will continue to follow BSP, policy and procedures to ensure [client #1's] safety." The investigation was not thorough. The investigation did not address there was insufficient staff at the time of the incident to implement client #1's BSP. On 1/13/16 at 12:46 PM, a review of client #1's 9/30/14 BSP indicated in the absent without notification or permission section, "Follow [client #1] either in vehicle or on foot to maintain line of sight and to maintain level of safety." On 1/14/16 at 3:37 PM, the PD indicated she was unsure what the staffing level at the facility-operated day program was supposed to be. The PD indicated she instructed the day program to ensure there were at least two staff present when client #1 attended the day program to ensure there was sufficient staff to implement her plan. On 1/15/16 at 12:29 PM, the PD indicated the investigation should have addressed there was insufficient staff at the time of the incident. The PD indicated the investigation should have included documentation of corrective action taken			

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	to address the staffing level at the day program. On 1/13/16 at 8:48 AM, the Day Program Program Director (DPPD) indicated client #1 had not eloped from the day program in the past 12 months without staff following her. The DPPD indicated the day program staff monitor client #1 from inside the building when she smokes. The DPPD indicated the day program staff did not go outside to monitor client #1's whereabouts. 6) On 6/29/15 at 7:15 PM, client #4 wanted to use the house phone. Client #1 was on the phone. When client #1 would not give client #4 the phone, client #4 hit client #1. Client #1 hit client #4. Client #4 threw her headphones and started screaming. Client #1 shoved a wheelchair into the wall. There was no documentation the facility conducted an investigation. On 1/14/16 at 3:37 PM, the PD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The PD indicated the facility had a policy and procedure prohibiting abuse of the clients. On 1/15/16 at 12:29 PM, the PD indicated the facility should conduct investigations			

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	of client to client abuse. 7) On 5/11/15 at 4:30 PM while riding in the group home van, client #4 was upset the van stopped at another group home. Client #4 scraped client #1's arm requiring first aid. Client #1 slapped client #4 on the arm. There was no documentation the facility conducted an investigation. On 1/14/16 at 3:37 PM, the PD indicated client to client aggression was considered abuse and the facility should prevent abuse of the clients. The PD indicated the facility had a policy and procedure prohibiting abuse of the clients. On 1/15/16 at 12:29 PM, the PD indicated the facility should conduct investigations of client to client abuse. 8) On 4/8/15 at 6:30 PM, client #1 was upset when she was picked up at the facility-operated day program. Upon arrival to the group home, staff heard client #1 yelling. Staff went to client #1's bedroom and observed client #1 take an object and stab herself twice on the forearm. Client #1 dropped the object. Staff applied pressure to stop the bleeding and called for an ambulance. Client #1 was taken to the emergency room and received four stitches. The			

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	4/9/15 BDDS report indicated, "Follow up instructions were to follow up with [name of counseling center] for group and individual therapy and to keep sharp objects out of reach." There was no documentation the facility conducted an investigation. On 1/15/16 at 12:29 PM, the PD indicated she was not instructed to conduct an investigation. The PD indicated there was no corrective action taken. The PD indicated client #1 used a pair of scissors to stab herself that she obtained from the office area of the group home. The PD stated, "Someone failed to lock up the sharps." The PD indicated at the time of the incident the sharps in the home were to be locked up. On 1/13/16 at 1:35 PM, the Area Director (AD) indicated the facility did not conduct an investigation. The AD stated he "didn't see a need for an investigation." The AD indicated the staff was not negligent. The AD stated it was "evident that staff was not negligent." The AD stated, "with the knowledge we had it was evident what happened." 9-3-2(a)			

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W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 2 of 49 incident/investigative reports reviewed affecting client #1, the facility failed to ensure appropriate corrective actions were taken following incidents of elopement from the facility-operated day program. Findings include: On 1/12/16 at 12:38 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 9/30/15 at 2:04 PM, client #1 eloped from the facility-operated day program. The 10/5/15 Investigation Summary indicated, "Staff was by herself with 3 clients and called an employee of TSI and she was there within minutes. [Client #1] made it down the road to [name of gas station] and staff got her into the car and brought her back to day program." Client #1's interview in the investigation indicated, "...I wanted to smoke and [name of day program staff #1] would not let me go outside. I can smoke if I want to. She couldn't leave	W 0157	The PD (QIDP) was retrained on Incident Reporting and Investigation Completion and Thoroughness and completing recommended corrective actions. The Area Director will review investigations with the Program Director weekly to ensure completion and thoroughness of investigations that occurred that week and ensure appropriate corrective action is taken based on the outcomes of investigations. Persons Responsible: Program Director (QIDP), Area Director	02/19/2016

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	because there were other clients here...." Day program staff #1's interview in the investigation indicated, "[Client #1] wanted to go outside. When I explained that were were going an activity and that when the other staff get (sic) back then I would go out with her. She got mad and walked out the front door. There were 3 other clients in the building so I could not leave...." The Conclusion of the investigation indicated, "Evidence supports staff intervened appropriately." The Recommendations section indicated, "Staff will continue to follow BSP, policy and procedures to ensure [client #1's] safety." There was no documentation of corrective action to ensure there was sufficient staff at the facility-operated day program. On 1/13/16 at 12:46 PM, a review of client #1's 9/30/14 BSP indicated in the absent without notification or permission section, "Follow [client #1] either in vehicle or on foot to maintain line of sight and to maintain level of safety." On 1/14/16 at 3:37 PM, the PD indicated she was unsure what the staffing level at the facility-operated day program was supposed to be. The PD indicated she instructed the day program to ensure			

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	there were at least two staff present when client #1 attended the day program to ensure there was sufficient staff to implement her plan. On 1/15/16 at 12:29 PM, the PD indicated the investigation should have included documentation of corrective action taken to address the staffing level at the day program. 2) On 3/18/15 at 9:50 AM at the facility-operated day program, client #1 was sitting in the program room. When the staff was occupied with another client, client #1 snuck out the front door and started walking toward the gas station. Client #1 indicated she went to the gas station to pick up cigarette butts to smoke. Client #1 was observed by a staff going to the day program. The staff called the day program and client #1 was transported back to the day program. Client #1's interview in the 3/19/15 Investigation Summary indicated, "...I was looking for cigarette butts to smoke. I want to smoke but everybody says that I can't... PD asked [client #1] if she knew that smoking other peoples (sic) cigarette butts could make her sick, [client #1] stated, 'I don't care. I have done it before and not got sick.'" The Conclusion of the investigation indicated, "Evidence supports staff intervened appropriately." There was no documentation of			

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	corrective action taken following the incident in the Investigation Summary. The corrective action section was blank. On 1/15/16 at 12:29 PM, the PD indicated the facility should have implemented corrective action following the incident. 9-3-2(a)			
W 0159 Bldg. 00	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review and interview for 4 of 4 clients in the sample (#1, #3, #4 and #7) and 4 additional clients (#2, #5, #6 and #8), the facility's Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor the clients' program plans from January 2015 to December 2015. The QIDP failed to ensure client #1's program plans were updated/revised to reflect, starting on 12/1/15, client #1's guardian approved she could smoke cigarettes. Client #1's program plans did not indicate client #1 needed restricted access to a lighter. Client #1's program plans did not indicate	W 0159	The Program Director (QIDP) and Behavior Analyst were retrained on 2/1/16 on Program Plan Reviews, Monitoring and Implementation for ISP, BSP and Training Objectives. The PD (QIDP) will meet with the Area Director at least monthly to review any changes made to plans to ensure compliance. Client #1's Behavior Support Plan has been updated including the changes approved by guardian and staff have been trained on the updated plan both in the home and at the day program. Staffing schedules in the home have been updated to ensure there are sufficient staff at all times to prevent client #1 from eloping. The PD monitors the schedules weekly to ensure	02/19/2016

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	the staff was to be outside with her while she smoked due to elopement. The QIDP failed to update and revise the clients' program plans when the clients achieved or failed to achieve the plans. The QIDP failed to ensure the clients' training objectives were expressed in measurable indices of performance. The QIDP failed to ensure there was sufficient staff at the group home and facility-operated day program to prevent client #1 from eloping. The QIDP failed to ensure the overnight evacuation drills were conducted at varied times. The QIDP failed to ensure clients #4, #5 and #6 participated in meal preparation and serving themselves. The QIDP failed to ensure the clients' finances were accounted for and there was a system in place to reconcile the clients' savings accounts. Findings include: 1) On 1/13/16 at 12:46 PM, a review of client #1's record was conducted. Client #1's Monthly Summaries, dated January 2015 to December 2015, indicated "Continue" for all of her training goals and objectives. The Monthly Summaries did not include the criteria client #1 was to achieve in order to meet her training objectives. The Monthly Summaries did not indicate whether or not client #1 met		sufficient staff are on duty and staff in the home have been trained to contact a supervisor immediately if there are problems with sufficient staff when they are on duty. The Day Program staff were retrained on ensuring their schedule has sufficient staffing to prevent client #1 from eloping. The PC (HM) was retrained to ensure that all evacuations drills are completed according to the schedule and drills are completed at varied times on each shift each quarter. The PD (QIDP) will review all drills after completion and will ensure they are completed correctly or another drill will be completed. Staff in the home were retrained on providing appropriate meal time assistance to clients during meal prep and serving selves during meals and ensuring clients participate according to their developmental level. Mealtime observations will be completed to ensure staff are assisting clients appropriately based on their needs. Persons Responsible: Program Coordinator, Program Director (QIDP), Area Director	

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	or did not meet her training objectives. The Monthly Summaries indicated client #1's training objectives did not change and were not revised or updated from January 2015 to December 2015. There was no documentation indicating whether or not client #1 made progress on meeting her training objectives. From January 2015 to June 2015, the summaries indicated, "Overall no changes, continue current programming." On 1/13/16 at 1:32 PM, a review of client #3's record was conducted. Client #3's Monthly Summaries, dated January 2015 to December 2015, did not include the criteria client #3 was to achieve in order to meet her training objectives. The Monthly Summaries did not indicate whether or not client #3 met or did not meet her training objectives. The Monthly Summaries indicated client #3's training objectives did not change and were not revised or updated from January 2015 to December 2015. There was no documentation indicating whether or not client #3 made progress on meeting her training objectives. From January 2015 to December 2015, the summaries indicated, "[Client #3] is adjusting well to the group home." From January 2015 to December 2015, the summaries were blank in the Recommendations section for each training objective. From January			

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	2015 to December 2015, the Monthly Summary Action Plan section was blank. On 1/14/16 at 10:43 AM, a review of client #4's record was conducted. Client #4's Monthly Summaries, dated January 2015 to December 2015, indicated "Continue" for all of her training goals and objectives. Client #4's Monthly Summaries, dated January 2015 to December 2015, did not include the criteria client #4 was to achieve in order to meet her training objectives. The Monthly Summaries did not indicate whether or not client #4 met or did not meet her training objectives. The Monthly Summaries indicated client #4's training objectives did not change and were not revised or updated from January 2015 to December 2015. There was no documentation indicating whether or not client #4 made progress on meeting her training objectives. From January 2015 to July 2015, the summaries indicated, "[Client #4] seemed to have yet another pretty good month. Doing well. Overall no changes, continue current programming." On 1/14/16 at 11:11 AM, a review of client #7's record was conducted. Client #7's Monthly Summaries, dated January 2015 to December 2015, indicated were blank for all of her training goals and			

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	objectives in the Recommendations section. The Monthly Summaries did not include the criteria client #7 was to achieve in order to meet her training objectives. The Monthly Summaries did not indicate whether or not client #7 met or did not meet her training objectives. The Monthly Summaries indicated client #7's training objectives did not change and were not revised or updated from January 2015 to December 2015. There was no documentation indicating whether or not client #7 made progress on meeting her training objectives. From January 2015 to May 2015, the summaries indicated, "[Client #7] is adjusting well to the group home. Things are going very well with [client #7] (smiley face)." From June 2015 to December 2015, the summaries indicated, "[Client #7] is getting along great. Things are going very well with [client #7] (smiley face)." From January 2015 to December 2015, the Monthly Summary Action Plan section was blank. On 1/13/16 at 1:49 PM, the Program Director (PD) indicated she did not change or revise the clients' training goals and objectives when the clients met/not met the objectives. The PD stated, "I don't have time." On 1/19/16 at 1:01 PM, the PD indicated the summaries she completed did not indicate whether or not			

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	the clients met/not met their training objectives. The PD indicated the summaries should include this information as well as the criteria for meeting the objectives. 2) Please refer to W104. For 8 of 8 clients living at the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility's QIDP failed to ensure client #1, #3, #4 and #7's program plans were integrated, coordinated and monitored from January 2015 to December 2015. The QIDP failed to ensure the clients' program plans were updated and revised when the clients achieved or failed to achieve their criteria for completion. The QIDP failed to ensure client #1's program plans were updated/revised to reflect, starting on 12/1/15, client #1's guardian approved she could smoke cigarettes. The QIDP failed to ensure client #1's program plans indicated the supervision level she needed while she was smoking. The QIDP failed to ensure staff did not unnecessarily restrict client #1's access to a lighter. The QIDP failed to ensure client #1's program plans indicated staff was to be outside with her while she smoked due to elopement. The QIDP failed to ensure there was sufficient staff at the group home to prevent client #1 from eloping. The QIDP failed to ensure failed to ensure there was a system in			

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	place to reconcile clients' savings accounts. The QIDP failed to implement its policies and procedures to prevent client to client abuse, report an incident of possible financial exploitation to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner for client #3, report an incident of possible financial exploitation to BDDS for an incident of possible exploitation to BDDS for client #4, initiate an investigation of client #3 and #4's missing money discovered during the survey, ensure there was sufficient staff to implement client #1's Behavioral Support Plan, ensure client #1's plan indicated staff was to supervise her in person when she went out to smoke, conduct thorough investigations and take appropriate corrective actions to address client #1's elopement from the facility-operated day program. 3) Please refer to W140. For 2 of 4 clients in the sample (#3 and #4), the QIDP failed to ensure staff kept a full and complete accounting of the clients' personal funds. 4) Please refer to W186. For 8 of 8 clients living at the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the QIDP failed to ensure there was sufficient staff to manage and supervise the clients in			

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	accordance with their individual program plans. 5) Please refer to W231. For 4 of 4 clients in the sample (#1, #3, #4 and #7), the QIDP failed to ensure the clients' training objectives were expressed in measurable indices of performance. 6) Please refer to W240. For 1 of 4 clients in the sample (#1), the QIDP failed to ensure client #1's program plan was updated/revised to indicate the staff was to provide direct supervision while client #1 smoked and client #1 was to return her lighter to staff after she lit her cigarette. 7) Please refer to W441. For 8 of 8 clients living at the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the QIDP failed to ensure evacuation drills were held under varied conditions during the night shift. 8) Please refer to W488. For 1 of 4 clients in the sample (#4) and two non-sampled clients (#5 and #6), the QIDP failed to ensure the clients were involved in preparing and serving their meals. 9-3-3(a)			

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W 0186 Bldg. 00	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. 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. Based on record review and interview for 8 of 8 clients living at the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to ensure there was sufficient staff to manage and supervise the clients in accordance with their individual program plans. Findings include: On 1/12/16 at 12:38 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 10/30/15 at 9:30 PM, the 10/31/15 BDDS report indicated, "[Client #1] returned home from (a) Halloween dance and became upset when another client began having a behavior. [Client #1] walked out the front door and up the road. Since there was only 1 staff on duty, the police were called, per policy,	W 0186	Staffing schedules in the home have been updated to ensure there are sufficient staff at all times to prevent client #1 from eloping. The PD monitors the schedules weekly to ensure sufficient staff are on duty and staff in the home have been trained to contact a supervisor immediately if there are problems with sufficient staff when they are on duty. The Day Program staff were retrained on ensuring their schedule has sufficient staffing to prevent client #1 from eloping. Observations will be completed by supervisory staff at least three times per week (one of these being during weekend hours) for four weeks and then at least two times per week ongoing, to monitor that staffing ratios are appropriate to meet clients' needs.Persons Responsible: Program Coordinator, Program Director (QIDP)	02/19/2016

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	because the rest of the clients could not be left alone. The police intercepted [client #1] a few blocks up the road and brought her back to the house...." This affected clients #1, #2, #3, #4, #5, #6, #7 and #8. The 11/2/15 Investigation Summary indicated, in part, "[Staff #8] was the only staff (sic) that time prior to other shift coming in and when [client #1] eloped, he followed BSP and called the police since he could not leave other clients unattended...." The interview with staff #8 indicated, in part, "[Staff #8] mentioned he called the Program Director and was told to call the police since he was the only one on duty. [Staff #8] said I didn't know what else to do, so I was just doing what I was told...." The Conclusion of the investigation indicated, "Evidence supports staff implemented BSP appropriately." The Recommendations section indicated, "Program Director met with Program Coordinator and put into place that 2 people must be on site at all times when [client #1] is present. For elopement purposes, 2 staff should be present to that one can follow her, and one can stay with other clients. PC know (sic) that if any time there is a time lapse, PC is to find coverage or cover it herself."			

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	On 1/15/16 at 8:51 AM, the PC indicated staff #8 left the party early without notifying her. The PC indicated she was going to meet him at the party to ensure there was two staff on the van during transport on the way back to the group home and two staff at the house once they arrived. On 1/12/16 at 1:38 PM, a 9/14/15 Staff Training form indicated, "Staff need to call supervisor with questions with scheduling. Call immediate supervisor during regular business hours and on-call PC after hours and on weekends. If you are scheduled alone, please report this immediately. Due to client behavior support plans, we cannot fully adhere to the guidelines explained if we have insufficient staffing while at work...." On 1/12/16 at 1:38 PM, a 9/14/15 Record of Discussion was given to the PC due to a staff being by herself during a client elopement. The staff was unable to implement the client's BSP due to insufficient staffing at the home. The Action being taken section indicated, "Training to staff, BSP training, reportable incident trainings and on-call procedures for insufficient staffing." On 1/14/16 at 3:37 PM, the PD indicated the incident occurred due to a			

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	miscommunication between the day program staff and the group home staff. The PD stated regarding there being one staff working at the time, "I questioned it as well." The PD indicated staff #8 and another staff were supposed to go to the house. The PD indicated staff #8 should have reported to the PC he was working alone, as previously instructed. The PD indicated staff #8 did not report he was working alone until after client #1 eloped. The PD indicated staff #8 reported the incident to her and indicated he was working alone. The PD indicated staff #8 reported he did not know why he was working alone. The PD indicated the PC told her there was another staff from the party who was supposed to ride with the clients and staff #8 to the group home but this did not occur. 2) On 9/30/15 at 2:04 PM, client #1 eloped from the facility-operated day program. The 10/5/15 Investigation Summary indicated, "Staff was by herself with 3 clients and called an employee of TSI and she was there within minutes. [Client #1] made it down the road to [name of gas station] and staff got her into the car and brought her back to day program." Client #1's interview in the investigation indicated, "...I wanted to smoke and [name of day program staff #1] would not let me go outside. I can			

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	smoke if I want to. She couldn't leave because there were other clients here...." Day program staff #1's interview in the investigation indicated, "[Client #1] wanted to go outside. When I explained that were were going an activity and that when the other staff get (sic) back then I would go out with her. She got mad and walked out the front door. There were 3 other clients in the building so I could not leave...." The Conclusion of the investigation indicated, "Evidence supports staff intervened appropriately." The Recommendations section indicated, "Staff will continue to follow BSP, policy and procedures to ensure [client #1's] safety." On 1/13/16 at 12:46 PM, a review of client #1's 9/30/14 BSP indicated in the absent without notification or permission section, "Follow [client #1] either in vehicle or on foot to maintain line of sight and to maintain level of safety." On 1/14/16 at 3:37 PM, the PD indicated she was unsure what the staffing level at the facility-operated day program was supposed to be. The PD indicated she instructed the day program to ensure there were at least two staff present when client #1 attended the day program to ensure there was sufficient staff to implement her plan.			

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	3) On 9/12/15 at 3:15 PM, client #1 told staff she was going to lie down to take a nap. While staff was assisting other clients with making dinner client #1 went out the back door and eloped. While staff was conducting checks approximately 10 minutes later, staff noticed client #1 was not in her room. Staff looked out the front door and observed client #1 walking up the street and out of line of sight. Staff called the police and the police returned her to the home. Client #1 indicated she was on her way to a store to find cigarettes. The 9/14/15 Investigation Summary indicated in the Factual Findings section, "Staff [#8] was working at [name of group home] alone from after day program (4:00 PM) until 6 PM when 2 staff was (sic) to come in. Within minutes of noticing that [client #1] was not in her bedroom, she was noticed walking up the street. Unable to follow her, [staff #8] called the police and policed (sic) picked her up on the road and returned her to the group home. Staff was asked why he was working alone, he mentioned he was OK with working alone for the 2 hours until the second staff got there. PD did a record of discussion of Program Coordinator explaining importance of sufficient staffing. PD also did a staff training on 9/14/15 to let staff know that			

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	if they are ever alone while at work, to call immediate supervisor and if after hours, to call on-call and report staffing issue." The Conclusion of the investigation indicated, "Evidence supports staff implemented BSP appropriately." This affected clients #1, #2, #3, #4, #5, #6, #7 and #8. On 1/15/16 at 11:39 AM, a communication from the Program Coordinator to the group home staff indicated, "While I was out on vacation [PD] held a meeting on 9-14-15. This meeting was over what staff should do if they are left alone with [client #1], because of recent elopements from [client #1]. There is to be always two staff on shift. If for some reason an error in the schedule or a no call no show staff should notify myself or [PD] immediately... This starts immediately." On 1/13/16 at 12:46 PM, a review of client #1's record was conducted. Client #1's 8/4/15 Individualized Support Plan (ISP) indicated she needed 24 hours a day, 7 days a week (24/7) awake supervision. The ISP indicated she had the following targeted maladaptive behaviors: self-injurious behaviors, runs/wanders away, temper outbursts, false reporting, stealing and verbal aggression.			

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	On 1/14/16 at 11:05 AM, a focused review of client #2's record was conducted. Client #2's 8/26/15 ISP indicated he had the following targeted behaviors: verbal aggression, physical aggression, refusals, hallucinations and runs/wanders away. On 1/13/16 at 1:32 PM, a review of client #3's record was conducted. Client #3's 9/28/15 ISP indicated she had the following targeted maladaptive behaviors: verbal aggression, false reporting, inappropriate sexual behavior and resistance to instruction. Client #3's ISP indicated she needed "24/7 protective oversight." On 1/14/16 at 10:43 AM, a review of client #4's record was conducted. Client #4's 7/28/15 ISP indicated she had the following maladaptive behaviors targeted for reduction: physical assault, self injurious behaviors, stealing, temper outbursts and inappropriate nudity. The ISP indicated, in part, "24/7 awake supervision but is allowed to be alone in common areas inside and outside the home with frequent checks." On 1/14/16 at 11:09 AM, a focused review of client #5's record was conducted. Client #5's 8/4/15 ISP			

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	indicated he had the following maladaptive behaviors targeted for reduction: physical assault, self injurious behavior, public masturbation and dropping to the floor. The ISP indicated client #5 needed, "24 hour awake supervision required." On 1/14/16 at 11:02 AM, a focused review of client #6's record was conducted. Client #6's 7/28/15 ISP indicated, in part, "Does client require monitoring during bathing for any health related reason: Yes Describe form of supervision provided: Requires total assistance. Unable to bathe independently." The ISP indicated he required, "24/7 awake supervision." On 1/14/16 at 11:11 AM, a review of client #7's record was conducted. Client #7's 4/9/15 ISP indicated, in part, "24/7 awake staff but able to remain alone in bedroom, bathroom." On 1/14/16 at 11:49 AM, a focused review of client #8's record was conducted. Client #8's 8/3/15 ISP indicated, in part, "24/7 supervision." On 1/14/16 at 3:37 PM, the PD indicated the group home should have at least two staff during waking hours to implement the clients' program plans. The PD			

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	indicated with one staff, client #1's program plan could not be implemented as written. 9-3-3(a)			
W 0231 Bldg. 00	483.440(c)(4)(iii) INDIVIDUAL PROGRAM PLAN The objectives of the individual program plan must be expressed in behavioral terms that provide measurable indices of performance. Based on record review and interview for 4 of 4 clients in the sample (#1, #3, #4 and #7), the facility failed to ensure the clients' training objectives were expressed in measurable indices of performance. Findings include: On 1/13/16 at 12:46 PM, a review of client #1's record was conducted. Client #1's 8/4/15 Individualized Support Plan (ISP) indicated she had the following formal goals: brush her gums daily before work with no more than one verbal prompt for three consecutive months, leave the target area with no more than two verbal prompts when staff prompt her to exit during another client's displayed targeted behavior, identify the name and milligrams of her psychotropic	W 0231	The Program Director (QIDP) and Behavior Analyst were retrained on 2/1/16 on Program Plan Reviews, Monitoring and Implementation for ISP, BSP and Training Objectives. The PD (QIDP) will meet with the Area Director at least monthly to review any changes made to plans to ensure compliance. Persons Responsible: Program Director (QIDP), Area Director	02/19/2016

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	medications during each med pass daily with no more than one verbal prompt for three consecutive months, thoroughly clean her bedroom one time per week to include dusting, sweeping and changing/washing her bed clothes with no more than two verbal prompts for three consecutive months, complete daily household chore with no more than one verbal prompt for three consecutive months, complete the steps in her laundry routine at least one time per week with no more than one verbal prompt for three consecutive months, attend day program on scheduled days, go on at least one group outing per week to increase peer relationships and social skills training, exercise for ten minutes three times per week with no more than two verbal prompts for three consecutive months, adhere to her diet plan ordered by her physician to maintain a healthy lifestyle by not actively seeking additional items to eat in between meals, including stealing food, with no more than one verbal prompt as needed, count back change after it was handed back to her after a purchase. Client #1's program plan did not consistently include the number of months/quarters she needed to meet her goals to move on to the next step. There was no documentation of the next step once client #1 met her goals.			

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	On 1/13/16 at 1:32 PM, a review of client #3's record was conducted. Client #3's 9/28/15 ISP indicated she had the following formal goals: Go on at least 2 community outings with peers weekly with no more than one verbal prompt, increase her medication knowledge by naming one medicine and reason with no more than one verbal prompt daily, increase daily living skills by performing the steps of her hygiene routine two times weekly with no more than two verbal prompts, maintain hygiene by performing steps of her hygiene routine daily with no more than two verbal prompts, and improve her financial skills by making a purchase in the community two times a month and giving the receipt and change to the Program Coordinator/staff with no more than two verbal prompts. There was no documentation on how many months/quarters client #3 needed to meet the goal in order to move to the next step of the training goal. There was no documentation of the next step once client #3 met the goal. On 1/14/16 at 10:43 AM, a review of client #4's record was conducted. Client #4's 7/28/15 ISP indicated she had the following formal goals: exercise for ten minutes three times per week with no more than two verbal prompts for three consecutive months, participate in a			

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	community outing at least one time per week with no more than two verbal prompts for three consecutive months, pour her juice to take her medications during each med pass independently from staff for three consecutive months, use hand sanitizer before med pass Independently for three consecutive months, thoroughly brush her teeth for two minutes every morning with no more than one verbal prompt for three consecutive months, complete her daily household chore independently for three consecutive months, thoroughly clean her bedroom including sweeping, dusting, and changing/washing her bed clothes one time per week with no more than one verbal prompts for three consecutive months, wash her private areas thoroughly with a wash cloth during daily shower with with no more than two verbal prompts for three consecutive months, pick out an outfit to wear every morning and dress herself with no more than one verbal prompts for three consecutive months, express her wants and needs more effectively to staff as needed on a daily basis to explore additional means of communicating, and make a purchase one time per month by handing the cashier the money for her purchase with no more than two verbal prompts with staff assistance as needed. Client #4's program plan did not			

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	consistently include the number of months/quarters she needed to meet her goals to move on to the next step. There was no documentation of the next step once client #4 met her goals. On 1/14/16 at 11:11 AM, a review of client #7's record was conducted. Client #7's 4/9/15 ISP indicated she had the following formal goals: complete all steps of daily hygiene with no more than two verbal prompts each day, make one side dish two times weekly with no more than one verbal prompt, participate in two community outings each week with no more than two verbal prompts, participate in a group activity with peers once a week no with no more than two verbal prompts, complete five addition problems and five multiplication problems with staff once a week with no more than two verbal prompts, and name her medications during medication pass each day with no more than one verbal prompt. There was no documentation on how many months/quarters client #7 needed to meet the goal in order to move to the next step of the training goal. There was no documentation of the next step once client #7 met the goal. On 1/19/16 at 1:01 PM, the Program Director (PD) indicated some of the clients' goals indicated the criteria needed			

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	in order for the clients to meet the training goal. The PD indicated the clients' goals should indicate the criteria needed in each formal goal. The PD indicated the next step should also be listed in the plan. 9-3-4(a)			
W 0240 Bldg. 00	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, interview and record review for 1 of 4 clients in the sample (#1), the facility failed to ensure client #1's program plan was updated/revised to indicate the staff was to provide direct supervision while client #1 smoked. Findings include: On 1/12/16 from 3:48 PM to 5:55 PM, an observation was conducted at the group home. At 4:14 PM, client #1 went out to smoke. Client #1 went outside in the front of the group home to smoke. The PC, staff #1 and staff #6 did not go outside with client #1 while she smoked. At 5:02 PM when client #1 went out to smoke, the PC went outside with her.	W 0240	The Program Director (QIDP) and Behavior Analyst were retrained on 2/1/16 on Program Plan Reviews, Monitoring and Implementation for ISP, BSP and Training Objectives. The PD (QIDP) will meet with the Area Director at least monthly to review any changes made to plans to ensure compliance. Client #1's Behavior Support Plan has been updated including the changes approved by guardian and staff have been trained on the updated plan both in the home and at the day program. Persons Responsible: Program Director (QIDP), Area Director	02/19/2016

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	On 1/12/16 at 4:20 PM, the PC indicated client #1 could go outside to smoke by herself. The PC indicated the staff monitored her through the windows of the group home. On 1/13/16 from 6:06 AM to 7:50 AM, an observation was conducted at the group home. At 6:06 AM, client #1 and the PC were outside. Client #1 was smoking. At 7:03 AM when client #1 went outside to smoke, the Program Director (PD) went outside with client #1. On 1/13/16 at 12:25 PM, the PD indicated the staff was supposed to be outside with her after the 11/8/15 incident when she eloped while smoking. On 1/13/16 at 1:28 PM, the PD indicated client #1's plan should have been updated after the 12/1/15 meeting with the guardian to discuss smoking. The PD indicated she discussed with the Behavior Consultant that client #1 should be in line of sight while smoking. The PD indicated it was her intention the staff was to be outside with her while she smoked. On 1/12/16 at 12:38 PM, a review of the facility's incident/investigative reports was conducted and indicated the			

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	following: On 11/8/15 at 6:30 PM, client #1 eloped from the home without staff's knowledge. The police were conducted and found her. Client #1 made threats of self-harm and the police took her to the hospital for an evaluation. The 11/11/15 Investigation Summary indicated, in part, "[Staff #8] inquired as to where [client #1] was by asking [staff #1] and [staff #1] reported that [client #1] was outside on the back porch." The investigation indicated, "...[Staff #8] stated that he asked [staff #1] where [client #1] was. [Staff #8] stated that [staff #1] said she had just checked on her outside and she was fine. [Staff #8] said he went to check on her because he 'had a feeling she left' so he went outside and looked for her and couldn't find her so he got in his car and drove around and looked for her for about 10-15 minutes and couldn't find her so he called the police for help. [Staff #8] said it had been about 2-3 minutes since [staff #1] said she had seen [client #1] before he asked about her and then started looking for her...." Client #1 was located about a mile from the house. The investigation indicated, "[Client #1] stated that [staff #1] had come out to check on her and when [staff #1] went back into the house, she walked away... She stated that after dinner, she took her e-cigarette outside on the back deck to smoke but she wanted real cigarettes...."			

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	The Conclusion of the investigation indicated, "Evidence supports staff intervened appropriately. Evidence supports staff implemented BSP appropriately." The Recommendations section indicated, "Continue to follow BSP and update as needed. Will discuss with team if changes are needed to supervision level in the home while in common areas or while outside smoking." On 1/13/16 at 12:46 PM, a review of client #1's record was conducted. Client #1's 8/4/15 Individual Support Plan and 11/9/15 BSP were not revised/updated after client #1's guardian approved of her smoking one cigarette per hour on 12/1/15. The facility failed to update/revise client #1's plans to reflect the changes with her smoking. The 12/1/15 Meeting Notes indicated, in part, "Smoking cigarette every hour... 6 AM - 9 PM...." On 1/14/16 at 12:19 PM, the PD indicated following the observations at the group home, the PD reviewed client #1's plan. The PD indicated after reviewing client #1's plan, the staff implemented the plan as written. The PD indicated, however, the staff needed to go outside with client #1 while she smoked to be able to monitor her due to			

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	elopement. The PD indicated after the 12/1/15 meeting she had with the guardian, client #1's Behavioral Support Plan (BSP) should have been updated to indicate staff was to go outside with her to monitor her while smoking. The PD indicated prior to the 12/1/15 meeting with the guardian, client #1 eloped from the group home while smoking. 9-3-4(a)			
W 0365 Bldg. 00	483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. Based on observation, interview and record review for 1 of 2 clients (#7) observed to receive their medications on 1/13/16, the facility failed to ensure staff initialed the Medication Administration Record after administering the client's medications. Findings include: On 1/13/16 from 6:06 AM to 7:50 AM, an observation was conducted at the group home. At 7:20 AM, client #7 received her medications from staff #7. Prior to staff #7 administering client #7's medications, staff #7 initialed the January	W 0365	Staff in the home were retrained on Medication Administration procedures. Med pass observations will be completed four times per week at various medication administration times by supervisory staff to ensure completed correctly or corrective action is given. Persons Responsible: Program Coordinator, Program Director (QIDP)	02/19/2016

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	2016 Medication Administration Record (MAR) with both her first and last initials. On 1/13/16 at 7:23 AM, staff #7 indicated she put her first initial on the MAR during her check to ensure the client was receiving the correct medications. Staff #7 indicated after administering the client's medications, she went back and initialed the MAR with her second initial. On 1/14/16 at 12:19 PM, the Program Director (PD) indicated the staff should initial the client's MAR after administering the client's medications, not before administering the medications. 9-3-6(a)			
W 0441 Bldg. 00	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. Based on record review and interview for 8 of 8 clients living at the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to ensure evacuation drills were held under varied conditions during the night shift. Findings include:	W 0441	The PC (HM) was retrained to ensure that all evacuations drills are completed according to the schedule and drills are completed at varied times on each shift each quarter. The PD (QIDP) will review all drills after completion and will ensure they are completed correctly or another drill will be completed.	02/19/2016

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	On 1/12/16 at 4:30 PM, a review of the facility's evacuation drills was conducted. During the night shift (10:00 PM to 7:00 AM), the facility conducted four evacuation drills from 1/12/15 to 1/12/16. On 3/10/15, the evacuation drill was held at 1:00 AM. On 6/12/15, the evacuation drill was held at 2:57 AM. On 9/8/15 and 12/9/15, the evacuation drills were held at 3:00 AM. This affected clients #1, #2, #3, #4, #5, #6, #7 and #8. On 1/14/16 at 12:14 PM, the Program Director (PD) indicated the facility did not vary the drills during the night shift. The PD indicated the evacuation drills during the night shift needed to be varied. 9-3-7(a)		Persons Responsible: Program Coordinator, Program Director (QIDP)	
W 0488 Bldg. 00	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 1 of 4 clients in the sample (#4) and two non-sampled clients (#5 and #6), the facility failed to ensure the clients were involved in preparing and serving their meals.	W 0488	Staff in the home were retrained on providing appropriate meal time assistance to clients during meal prep and serving selves during meals and ensuring clients participate according to their developmental level. Mealtime observations will be completed three times per week by	02/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G410	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/20/2016

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	Findings include: On 1/12/16 from 3:48 PM to 5:55 PM, an observation was conducted at the group home. At 5:16 PM, client #3 put potatoes on client #6's plate. Staff #6 was cutting up client #6's meat into bite sized pieces. At 5:20 PM, the Program Coordinator (PC) poured Ensure into client #6's cup. At 5:22 PM, staff #6 used the food processor to puree client #5's food as he was sitting at the dining room table. At 5:25 PM, staff #6 served applesauce to client #4. At 5:28 PM, the PC cut up client #4's meat. At 5:32 PM, staff #6 was in the kitchen washing dishes until 5:36 PM when the Program Director (PD) instructed her to stop to allow the clients to participate in meal clean up. At 5:36 PM, the PD served client #4's salad. At 5:40 PM, the PD poured juice for client #4. On 1/13/16 from 6:06 AM to 7:50 AM, an observation was conducted at the group home. At 6:10 AM, client #4 served herself cereal and then poured milk onto her cereal. At 6:14 AM, staff #7 served client #6's cereal and poured milk onto his cereal. At 6:14 AM, client #4 poured her own milk and juice into her cups. On 1/14/16 at 12:19 PM, the PD		supervisory staff to ensure staff are assisting clients appropriately based on their needs. Persons Responsible: Program Coordinator, Program Director (QIDP)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G410	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/20/2016

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	indicated the clients should serve themselves or be assisted to serve themselves during meals. 9-3-8(a)			