

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G153		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/17/2013	
NAME OF PROVIDER OR SUPPLIER PIKE COUNTY ARC - THIRD ST				STREET ADDRESS, CITY, STATE, ZIP CODE 403 S THIRD ST PETERSBURG, IN 47567			
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W000000	<p>This visit was for an investigation of complaint #IN00128669.</p> <p>Complaint #IN00128669: Substantiated, Federal/state deficiencies related to the allegation(s) are cited at W149 and W157.</p> <p>Dates of Survey: May 10, 15, and 17, 2013.</p> <p>Surveyor: Dotty Walton, QIDP</p> <p>Facility Number: 000689 AIM Number: 100234480 Provider Number: 15G153</p> <p>The following federal deficiencies reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review completed 5/21/13 by Ruth Shackelford, QIDP.</p>	W000000					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, for 4 of 10 facility incidents/reportable/investigations reviewed, for 1 of 3 sampled clients (client A), and 1 additional client (client D), the facility failed to implement policies and procedures which prohibited staff neglect by failing to prevent client A from eloping, failed to implement client A's behavior program and failed to prevent client to client physical aggression.</p> <p>Findings include:</p> <p>Review of agency reportable incidents and investigations on 5/10/13 at 1:30 PM indicated the following behavioral incidents, Bureau of Developmental Disabilities Services/BDDS reports, and a substantiated allegation of staff to client neglect involving client A:</p> <p>1. A BDDS report of 2/25/13 indicated on 2/23/13 at 2:40 PM client A became upset when she was questioned about a peer's missing money. Client A left the facility with staff in pursuit on foot. The staff did not have a walkie/talkie as per the client's "special services" behavior</p>	W000149	<p>Staff failed to follow client bsp and special services for elopement and physical aggression. Staff were re-trained on the agency's abuse and neglect policy (Form A) with emphasis on failing to follow client programming is considered neglect. The IDT met to develop a procedure to better monitor programming implementation by staff. The team developed a "Staff Competency Observation Form for Treatment Integrity" (Form B). The QMRP-D will be responsible for spending time in the home, observing staff, documenting staff's implementation of programming, and providing corrective feedback and/or re-training as needed.</p> <p>The QMRP-D will spend more time in the home and observe staff implementing all clients' programming. QMRP-D will document any problems on the observation form and address the issue immediately. This could include corrective feedback, modeling appropriate interventions, on site re-training, or disciplinary action.</p> <p>All staff will continue to receive training on clients' programming and the agency's abuse and</p>	06/03/2013			

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	<p>plan. The staff called the facility but the house phone was engaged. Client A eluded the staff and went into the house of a community friend and was out of sight "approximately 30 seconds" before she came out and returned to the facility with staff #12. The BDDS report indicated staff #12 was reprimanded for not following client A's program.</p> <p>2. A BDDS report of 2/25/13 indicated on 2/24/13 at 2:40 PM client A became upset when she slept through her 9:30 AM scheduled cigarette and demanded it at 11:30 AM while smoking. Staff was not sure if she could have the 9:30 AM cigarette. While staff #5 found out if she could have it, client A obtained another cigarette and went outside to smoke. Staff was not aware she was outside. Client A was on 24 hour supervision and was not supposed to be outside alone. A peer told staff #13 client A was outside and she was directed back into the facility. Client A left the facility with staff #5 in pursuit on foot. The staff did not have the walkie/talkie as per client A's program. Staff #5 lost sight of client A when she returned to the facility to get the van. Staff could not find client A but she returned on her own after 10 minutes. She was at a friend's house. According to the BDDS report, the 3 staff on duty were unsure who was client A's one on one</p>		<p>neglect policy before working with clients. The QMRP-Ds will routinely do observations in house and documents any problems on the observation form.</p> <p>The team will review the observation forms at least monthly to ensure the QMRP-D are doing the observations, documenting issues, and appropriately addressing concerns. The QMRP will be responsible for ensuring QMRP-Ds are implementing programming correctly themselves, know what they are looking for in the home, and know how to effectively correct staff.</p> <p>Systematic changes will be completed by 6/3/2013</p>	

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	<p>staff. The assigned staff were to be at arm's length of client A and have a walkie/talkie with then if they needed to do an on foot pursuit. All three staff were reprimanded for not implementing client A's behavior programming and violating agency policy.</p> <p>3. A BDDS report of 4/08/13 indicated on 4/05/13 at 3:30 PM client A came home upset with client D. Client A cursed client D and hit her on the back of her right shoulder. Staff were unable to calm client A and the LPN called for extra assistance at the agency office. Client D's father was at the facility to take client D on a home visit and witnessed the aggression.</p> <p>4. A BDDS report of 4/22/13 indicated on 4/21/13 at 8:45 PM client A took her evening medications and went into her bedroom. Staff were busy assisting other clients and the phone rang at 8:55 PM. A waiver consumer called to report client A was outside his window "a couple of blocks" from the facility. The incident report indicated client A had eloped through her bedroom window. The BDDS report indicated client A was on 24 hour supervision and the staff was to monitor the hallway outside her bedroom. There was no methodology for monitoring her bedroom window. Staff</p>						

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	<p>looked for client A, gave chase, lost sight of her for 15 minutes and she was returned to the facility at 10:00 PM.</p> <p>Review of agency policies/procedures on 5/15/13 at 3:30 PM indicated the agency prohibited client abuse/neglect. They had a policy "Consumer to Consumer Abuse Policy" (undated) which prohibited client to client abuse. "Individuals will be discouraged from using profane or obscene language towards others. Other behaviors that will be discouraged, including but not limited to be: verbal or physical aggression...willfully to cause harm to another resident." The review indicated the policy "Suspected Abuse and Neglect of Consumers" dated 8/31/11 indicated "Neglect and mistreatment is considered abusive and includes, but is not limited to,... failure to staff appropriately, failure to monitor or supervise a consumer's environment, failure to follow a consumer's individual plan...."</p> <p>Qualified Intellectual Disabilities Professional/QIDP #1 was interviewed on 5/15/13 at 3:45 PM and indicated staff had neglected to follow client A's special services/behavior program in regards to elopement and had failed to prevent the client A to client D physical aggression.</p>						

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	This federal tag relates to complaint #IN00128669. 9-3-2(a)				

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 3 sampled clients (client A), and 1 additional client (client D), the facility failed to complete corrective actions in regards to an incident of client to client aggression (no team meeting to discuss the incident and how similar incidents may be prevented).</p> <p>Findings include:</p> <p>Review of agency reportable incidents and investigations on 5/10/13 at 1:30 PM indicated the following behavioral incident/Bureau of Developmental Disabilities Services/BDDS report involving client A:</p> <p>A BDDS report of 4/08/13 indicated on 4/05/13 at 3:30 PM client A came home upset with client D. Client A cursed client D and hit her on the back of her right shoulder. Staff were unable to calm client A and the LPN called the agency office for extra staff support. Client D's father was at the facility to take client D on a home visit and witnessed the aggression. The agency's director came to the facility and implemented client A's behavior program (escort to her room/physical restraint to calm).</p>	W000157	<p>The facility was aware of an incident of client to client physical aggression but failed to have a team meeting to discuss details and formulate a corrective action plan to prevent future incidents. A new IDT policy (Form C) was written and implemented. A new "Corrective/Preventative Action Request" form (Form D) was developed.</p> <p>When the facility becomes aware of an incident of peer to peer aggression via contact notes, incident reports, verbal staff reports, etc, the IDT will meet to discuss the details of the incident and ways to prevent similar incidents from occurring in the future.</p> <p>All staff will document any form of peer to peer aggression observed. This documentation will be reviewed by the QMRP-D who will then bring concerns to the IDT. The IDT will meet to collect details of incident and discuss why incident may have happened and ways to prevent future incidents. A corrective action plan will then be developed and implemented.</p> <p>Whenever the QMRP-D receives a report of peer to peer aggression, they will complete the</p>	06/03/2013			

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	<p>Interview with client D on 5/15/13 at 4:30 PM indicated she had been cursed and hit on the back by client A in April 2013. She indicated her father had witnessed the incident and was going to press charges if it occurred again. Client D indicated client A's behavior was upsetting to her.</p> <p>Qualified Intellectual Disabilities Professional/QIDP #1 was interviewed on 5/15/13 at 3:45 PM and indicated the interdisciplinary team had failed to meet and discuss the incident of April 5, 2013. The interview indicated all staff involved in the incident should have documented and discussed the incident so future incidents could be avoided.</p> <p>This federal tag relates to complaint #IN00128669.</p> <p>9-3-2(a)</p>		<p>top portion of the "Corrective/Preventative Action Request" form and forward it to the QMRP. The QMRP will then call an IDT meeting. The team will investigate the incident and document investigation results and the corrective action on bottom portion of form. Once a corrective action has been developed, the QMRP will ensure it is implemented.</p> <p>Systematic changes will be completed by 6/3/2013</p>		

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