

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G483	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/20/2014
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W000000	<p>This visit was for the investigation of complaint #IN00156363.</p> <p>Complaint #IN00156363: Substantiated. Federal and state deficiencies related to the allegation are cited at W149, W252, W310 and W407.</p> <p>Dates of Survey: October 14, 15, 16, 17 and 20, 2014.</p> <p>Facility Number: 000997 AIMS Number: 100249410 Provider Number: 15G483</p> <p>Surveyor: Susan Reichert, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed October 29, 2014 by Dotty Walton, QIDP.</p>	W000000		
W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement</p>			

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

TITLE

(X6) DATE

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

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	<p>written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview for 3 of 4 sampled clients (clients A, C and D), the facility neglected to implement policy and procedure to protect clients C and D from physically aggressive behavior by client A and 1 of 1 injury of unknown origin.</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 10/14/14 at 2:32 PM and included the following:</p> <p>A BDDS report dated 7/5/14 indicated client A "attempted to go forcefully toward another housemate. Staff stepped between the two. [Client A] then went downstairs to that housemate's room and threw his TV off of the stand and began throwing that housemate's belongings." Client A "charged at the staff, hit staff in eye (sic) and forehead and scratched several times." Staff prompted other residents to go to their rooms per the "Behavior Crisis Plan." Corrective action indicated client A's medication had been changed in April, 2014 from Zyprexa (bi-polar) to Abilify (bi-polar). Client A's "behavior had improved for a time, but</p>	W000149	To assure compliance with W149, facility has revised Client A's behavior intervention plan to include specific protocol if Client A is agitated at time of transport from day services. Facility staff will prompt him for de-escalation. If after these attempts he continues to threaten harm to housemates, Client A will be transported separately after he has calmed. Staff training on this revision to occur on 11-17-14. Additionally, Behavioral Crises Response Plan (attachment A) has been revised. This revised plan outlines several additional interventions to assure Clients C and D and all other residents are protected from physically aggressive behavior. The additional interventions include; Step 1)- Revisions to this step include residents participating in practice drill in moving to the designated safe areas of the home. A practice drill was run on 10-31-14 to assure understanding of this procedure. One resident needed some physical assistance to move to a designated area. To assure maintenance of this skill, additional drills will be held on at least a quarterly basis. Drill Report form (Attachment B) Step 2) Authorization for on call supervisory staff to add additional staffing as needed to provide for one on one supervision for Client A when potentially aggressive	11/17/2014			

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	<p>agitation and aggression have been escalating over the past several weeks." Client A had rescheduled his appointment on 6/25/14 to 7/23/14 due to the psychiatrist's illness. "Staff will follow [client A's] behavior plan and Behavior Response Plan."</p> <p>A BDDS report dated 7/17/14 indicated client A was found with a contusion to his chest 1/8 inch wide and 3 and 1/2 inches long. Client A was unable to indicate the cause of the injury. An investigation indicated increased drowsiness since beginning Seroquel on 7/9/14 and the medication was reduced on 7/18/14. The investigation indicated the origin of the injury was "inconclusive" and corrective action indicated client A was sleeping downstairs temporarily so that staff can monitor him more closely.</p> <p>A BDDS report dated 7/19/14 indicated staff heard a noise and found client A had fallen out of bed causing a bloody nose and a raised 1 inch abrasion over his right eyebrow. Corrective action indicated client A would be monitored hourly.</p> <p>A BDDS report dated 8/31/14 indicated client A threw a laundry basket at client D and hit him in the knee. Staff stepped between the clients and prompted client</p>		<p>behaviors appear to be escalating. Step 3) The addition of a prepared alternative location (within home office facility) where Client A can be served away from all other residents during a cycle of aggressive/destructive behaviors. Staff training on revised Crises Response Plan to occur on 11-17-14 Persons Responsible: QIDP and Behavior Consultant For response to W149 finding for injury of unknown origin to Client A, please see response at W310.</p>				

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	<p>A to stop the behavior. Client A was asked to go to his room and he refused. "A two person escort was attempted by staff to [client A's] room. [Client A] scratched staff and spit in staff's face. [Client A] then kicked staff in the shin and punched staff in the shoulder. [Client A]'s agitation continued with yelling, threatening and throwing items. Staff phoned the residential nurse who approved the administration of Ativan (anti-anxiety) 2 mg (milligrams). Corrective action indicated client A was in "a manic cycle of his bi-polar mood disorder." Staff were to continue to follow client A's behavior plan and the nurse had left a message with client A's psychiatrist regarding the incident on 9/2/14 "awaiting call back." The report indicated client D was not injured during the incident.</p> <p>A BDDS report dated 9/1/14 indicated client A had thrown stationary bicycle pedals at staff, threw trash cans, knocked off a roommate's belongings and a game system off his dresser, and threatened harm to others. Client A was asked to go to his room, but client A refused and continued walking through the house "yelling and threatening." Staff called the nurse and obtained approval to administer 2 mg (milligrams) prn (as needed) Ativan. The report indicated the</p>			

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	<p>facility staff were awaiting a call from the psychiatrist's office regarding client A's behavior.</p> <p>A BDDS report dated 9/3/14 indicated client A refused to put on a seat belt and "grabbed the staff's arm, hit off staff's glasses and spit in staff's face. Other clients were asked to get off the van and were transported home by another staff. [Client A] continued agitation of yelling and threatening. Ativan was given at 4:00 PM. [Client A's] behavior did not de-escalate throughout the evening. [Client A] continued agitation of yelling and threatening. Ativan 2 mg was given at 8 PM also." Corrective action indicated client A saw the psychiatrist on 9/4/14 and Clozaril (schizophrenia) was added as well as Ativan at 3 PM and 7 PM. "Staff will continue to monitor behavior and follow behavior plan."</p> <p>A BDDS report dated 9/7/14 indicated client A was taken to the ER (emergency room) after "extreme" aggression, physical aggression, and exhibiting "mania." Client A was given a Geodon 20 mg injection at the hospital, and was denied admission. The report indicated client A had gone to the ER on 9/6/14 due to "extreme" aggression and given an injection of Ativan 2 mg and prescribed Ativan 1 mg three times daily which was</p>			

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	<p>administered on 9/6/14 and 9/7/14. After returning from the ER on 9/6/14, client A threw objects, bit staff and didn't sleep through the night. Client A was restrained 3 times during the night due to his attempt to injure others. Client A slept 1-2 hours and upon awakening, client A immediately became aggressive again. Client A was restrained during the incident and then taken to the ER again on 9/7/14. The report indicated client A was not injured during the restraint. Corrective action indicated client A should follow up with his psychiatrist on 9/8/14. Client A's psychiatrist decreased client A's Ativan and increased client A's Seroquel from 100 mg to 300 mg and added Seroquel 100 mg at 3:00 PM. "Additional staff hours have been added to the schedule to assure safety."</p> <p>A BDDS report dated 9/9/14 indicated client A was yelling and threatening staff and attempted to hit staff. Twice during the incident a two person hold was implemented and client A was released within 10 minutes. Client A was not injured during the restraint. Corrective action indicated client A's psychiatrist increased client A's Seroquel.</p> <p>A BDDS report dated 9/15/14 indicated client A hit client C in the back while in the van with "no precipitating event." The</p>			

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	<p>report indicated client C was transported separately. Corrective action indicated "staff are consistently attempting to calm [client A] during his continued cycle of his bi-polar mood disorder. Corrective action indicated client A was to be transported separately from workshop on days when he threatened harm to other housemates. The report injured indicated client C was not injured.</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 10/14/14 at 3:14 PM. She indicated client A used to have periods of stability in behavior, but "those episodes (of stable behavior) have decreased in duration. September was a constant "episode of physically aggressive behavior and the facility was seeking alternative placement for him. She indicated client D had just stated to her "He's starting over again," and indicated client A had refused to put on his seat belt when he left workshop that day. When asked what actions had been taken to protect other clients from client A's physically aggressive behavior, she stated clients were told "to stay away from him. We try to keep clients and [client A] separated during episodes." She indicated staffing ratios had been increased to ensure there were 3 staff in the evenings for a period of time to address client A's</p>				

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	<p>behavior, and at least 2 overnight staff during client A's behavior episodes.</p> <p>Client A's records were reviewed on 10/14/14 at 3:15 PM. A Behavior Improvement Program dated 7/7/14 indicated target objectives of agitation (yelling, screaming, swearing, making negative or accusatory comments directed towards others, calling others' names, slamming doors, throwing items, and/or threatening to run away or harm others), physical aggression (harming or attempting to harm others, primarily hitting, kicking, shoving, and/or throwing objects at others, property destruction (damaging or attempting to damage property, primarily hitting, throwing, or knocking over items, objects or furniture) and making false statements (false accusations or saying things that are not true in order to gain desired attention and responses by others). The plan indicated "Most of [client A's] physical aggression appear to be secondary to his underlying mood disorder. Documentation and observation have indicated that [client A] has periods of time when he becomes extremely 'depressed.' During these times, [client] A becomes tired, withdrawn, non-responsive and does not interact with others. [Client A] also has periods of time where he appears to become 'manic.' During these times, he</p>						

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	<p>exhibits pressured speech, increased psychomotor activity, frequent episodes of irritability and agitation, and physical aggression directed toward staff and his housemates. Psychotropic medication has significantly helped to reduce the frequency of these cycles, but they do still occur, and the 'manic' cycles in particular are quite difficult to manage...Medications have continued to be adjusted in attempts of gaining better behavioral control. At times, [client A's] displays of aggression present a significant risk to those around him. Subsequently it is at times, necessary to utilize physical containment procedures to keep others in [client A's] vicinity safe. Historically, it has also been necessary to use a PRN medication if [client A] escalates to the extent that implementation of a manual restraint is deemed a safety concern, or when he continues to escalate and fails to calm....</p> <p>" The plan indicated a revision to his behavior program dated 7/5/14 indicating client A "has continued to struggle with extremely challenging behavior over the last year. He was taken to the emergency room earlier in the year, and a myriad of different medications have been attempted in an effort of decreasing his mood cycles. When these occur, [client A] becomes extremely agitated, aggressive, and destructive of property.</p>				

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	<p>On July 5, 2014, [client A] became out of control. He threw a television, charged after a staff, hit them in the face, then repeatedly struck and scratched them. He was administered an Ativan PRN to assist in calming down. The day before that, [client A] ripped a fire extinguisher off the wall. [Client A's] behavior is volatile, unpredictable, and has the potential to cause harm or injury to others. Restraint procedures, criteria for PRN usage, and the safe storage of knives and other sharp objects are all outlined in the current behavior program....."</p> <p>IDT (Interdisciplinary Team) meetings documentation and related staff training records were reviewed on 10/14/14 at 3:28 PM and included the following:</p> <p>Meeting notes dated 7/15/14 indicated client A had discontinued Zyprexa on 4/7/14 and started Abilify. The notes indicated client A had 1 incident of agitation in April (2014), 4 in May, and 5 in June. Client A had 1 incident of physical aggression in April, 4 incidents in May, and 5 in June. The behavior specialist indicated client A's plan had been modified and indicated "rapid cycling. Staff training 7/28/14. Discussed transition plan when comes home from [relative's]...."</p>						

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	<p>Meeting notes dated 10/7/14 indicated the psychiatrist had discontinued client A's 300 mg Seroquel and started 100 mg Seroquel due to sedation. The notes indicated client A's ER visits on 9/6/14, 9/7/14 and a visit to the psychiatrist on 9/4/14 indicated client A's Clozaril could not be started due to lab results. Client A had 15 incidents of agitation in July (2014), 2 in August, and "?" (sic) in September. Client A had 12 physical aggression incidents for July, 2 in August and "?" (sic) for September.</p> <p>A Behavior Plan Training/Review dated 10/6/14 indicated staff had been trained on all client behavior plans at the group home.</p> <p>A letter dated 9/11/14 from the behavior specialist to the psychiatrist was reviewed on 10/14/14 at 3:45 PM and indicated "As you know, our client [client A], has been struggling with extremely high intensity agitated, aggressive and destructive behaviors over the last several weeks. I know that medication changes are occurring, and we are all hopeful that his apparent manic cycle will end soon. The letter indicated client A had "become so out of control, that he had to be physically restrained on several occasions," and indicated on 9/7/14 staff</p>						

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	<p>had spent "over 6 hours with him at the Emergency Room ...Our intent was to get him admitted to [hospital #1], as we really felt that it was unsafe to continue trying to have [client A] remain at the group home. Unfortunately, even though the staff at [hospital #2] strongly felt [client A] should have been admitted to the Psychiatric Unit at [hospital #1], this did not occur, as the doctor from [hospital #1] denied his admission. Subsequently, the [hospital #2] ER staff then attempted to get [client A] admitted to the [hospital #3], however, this was also denied. I would like to have a 'plan' in place for staff to follow to ensure their and [client A's] safety should this situation re-occur. Do you have any suggestions as to what steps staff should take if we again feel that [client A's] behavior is so out of control hat (sic) he cannot be safely maintained....?"</p> <p>Client A's psychiatrist's visits documentation records were reviewed on 10/14/14 at 3:55 PM and indicated client A was seen on 7/29/14. Client A "has been oversedated (sic) by Seroquel 100 mg qAM (every morning) and 300 mg qhs (at bedtime). He fell out of bed several times and injured his face. He fell asleep at meal time. His family doctor stopped the 300 mg dose and gave the 100 mg dose at bedtime. This has worked</p>						

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	<p>well for several days with good behavior, adequate sleep and he is able to stay awake in the daytime." The recommendation indicated "stop Seroquel 300 mg continue Seroquel 100 mg qhs. Visit notes dated 9/4/14 indicated "has been much more agitated fighting with staff and peers. Throwing chairs, breaking things. This has been progressively worse over the last few years. Will start clozapine for agitation...." A visit note dated 10/2/14 indicated client A "is a little sedated by his medicines. He is still verbally abusive but has stopped being physically aggressive since his medications were increased. This is an improvement but not ideal. I don't want to increase his medicines further due to sedation but he could do better with behavior and mood stability." The note indicated client A's labs would be reviewed again and client A's Tegretol may be stopped and clozapine considered depending upon client A's lab results.</p> <p>The QIDP was interviewed again on 10/14/14 at 4:00 PM and indicated the behavior specialist had written a letter to the psychiatrist to ask about additional steps to take to protect clients in the home during client A's behavioral episodes. She indicated there had been fewer incidents currently than there were</p>						

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	<p>in September, 2014, but indicated since client A had refused to put a seat belt on prior to leaving after workshop that day, his refusal may indicate the start of escalating behavior. She indicated if client A's behavior escalated the plan included staff were to call the on call staff, and clients were removed from the area. When asked about the question marks for September, 2014 for client A, she stated behavior rates were missing for September as "It was kind of survival mode to keep everyone safe," and indicated training and behavior data was not recorded in September, 2014 due to staff's time and involvement in managing client A's behavior. She indicated client A's psychiatrist did not respond to the letter written by the behavior clinician.</p> <p>Observations were completed at the group home on 10/14/14 from 5:09 PM until 6:03 PM. Client B opened the door, then went in his bedroom. Client A sat in the living room in a chair and periodically uttered words that were not understood by the surveyor. Client F assisted staff #4 prepare dinner and client D set the table after watching TV. Client C sat at the kitchen table with client D watching client F and staff #4 in the kitchen prior to receiving his medications. Client G played basketball. Client E remained in his bedroom lying</p>			

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	<p>on his bed during the observation. Staff #3 recorded documentation and completed medication administration while staff #6 administered treatments for clients B and E.</p> <p>Staff #3 was interviewed on 10/14/14 at 5:10 PM. When asked about client A, he stated, "It's difficult to manage him; throwing, breaking objects, endangered other clients safety, verbal aggression and threats to clients and staff." He indicated client A had hit other staff and clients. He stated staff were able to prevent client A from hitting other clients "most of the time," and "every now and then he was able to hit clients, but caused no real harm." Staff #3 indicated client #3 was more calm due to the medications he was now taking, and stated, if not for the medications, "He would be his old self." He stated just prior to the surveyor's arrival, client A had become "very verbal" regarding his bed sheets regarding washing them, but staff had addressed his concerns and client A had calmed. He indicated client A would sometimes refuse to wear his seatbelt and stated, "Sometimes we'll wait him out and take some guys home first." He indicated client A was seated near the back of the van away from clients to protect clients. Staff #3 indicated no clients had left the home in the past other</p>				

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	<p>than to walk at the end of the property with the exception of one client who no longer lived there, but had taken a walk with staff when upset. He indicated the plan to address client A's behavior included encouraging clients to go to other areas of the house when client A's behavior escalated to protect them from physical aggression. Client A was to be encouraged to go to a quiet area when physically aggressive until calm. He indicated the staff then encouraged the clients to go about their day as usual. When asked if clients were safe in the home, he stated, "At this point they are safe. Without medication (for client A), No." He indicated client A was stable at this time and stated when client A had behaviors in the past, "It was hard to do active treatment with the other guys and we had to address [client A's] aggression."</p> <p>Client D was interviewed on 10/14/14 at 5:25 PM. When asked if he felt safe living in the group home, he indicated he did worry about client A and stated, "He's hard to handle. I don't want to talk about it too much." He stated, he had been pushed down the stairs "really hard" by client A, but had not fallen. He stated he thought it had occurred "about two weeks ago," but was unable to provide a date or further details other than to indicate staff</p>			

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	<p>had intervened. He indicated he was fearful of client but stated, "staff keep me safe," and "I feel safe halfway."</p> <p>Staff #4 was interviewed on 10/14/14 at 5:35 PM. He stated client A "Got into a groove of being aggressive all of the time. He usually cycles in and out, but last month didn't cycle out. A couple of times he had to be restrained and guided to another room. He was picking up large objects and throwing them; chairs, pedal and a fire extinguisher. Three weeks ago, when they got him on Seroquel, it helped tremendously with aggression, but now he is sleepy and he's not able to do a lot of stuff. Right before that we weren't able to function as a group home (due to client A's behavior) and [client A] had 1:1 (one to one) to staff for awhile for 1 and 1/1 to 2 weeks." He indicated the medication had helped client A. Staff #4 indicated client A had thrown flower pots outside at his car and damaged it. During the interview, a thud was heard in the living room where client A was sitting and staff #4 ran to check on him. He stated, "Oh good [staff #3] has him," and indicated he had been concerned client A had exhibited physical aggression when he heard the noise.</p> <p>Client G was interviewed on 10/14/14 at 5:40 PM and indicated he did not have</p>						

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	<p>concerns and felt safe living in the house. He indicated he was unaware of any clients being physically aggressive to others and no one had been physically aggressive to him.</p> <p>Staff #4 was interviewed on 10/14/14 at 5:45 PM. He indicated staff had parked on the street when the incident of client A damaging his car had occurred, but stated, "We got notice from the neighborhood we aren't to park on the street." He indicated no staff park on the street at this time. Staff #4 was unaware of any clients leaving the home without staff supervision in the 1 and 1/2 years since he worked at the group home.</p> <p>Staff #3 approached the surveyor on 10/14/14 at 6:00 PM and stated, "Just so you know, [client A] got upset earlier and stated, 'I'm not answering any questions,' and got up and threw a bike pedal. I went behind him to make sure he is relaxing in his room." He indicated client A had his own room and the thud that was heard during the interview with staff #4 was client A throwing the pedal. He indicated he placed the bike pedal in another room away from easy access to client A and no clients had been near him when he threw the pedal. Staff #3 showed the surveyor the bike pedal on a stand in an adjacent room to the living room where client A</p>			

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	<p>had been seated.</p> <p>The QIDP was interviewed on 10/15/14 at 1:30 PM and indicated she was unaware of any clients leaving the group home property with the exception of client E who had walked down the street, but came back.</p> <p>A Behavioral Crisis Response Plan dated 2/10/14 indicated "In the event that [client A] becomes agitated, staff should follow steps 1-6 of his behavior plan to prompt with step 6 being a 2 person escort to his room. In the event that [client A] demonstrates escalation behavior which is likely to become or does become aggressive or destructive in nature, all other residents of the home should be directed to a designated safe area away from him. Safe areas may include: the garage, or an adjacent room which has a door to serve as a 'partition' between the potentially aggressive individual and other individuals. Though it will likely be necessary for all available staff to assist in the safe de-escalation, and if necessary, containment of the individual who has become extremely agitated and/or aggressive, attempts to move to the area the other individuals have been directed to in order to visually check and verbally calm and encourage (sic) should occur. Once the 'crisis'</p>				

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	<p>situation has been successfully defused, de-briefing between staff members and other housemates should occur to help ensure others who had to move to a safe area now feel calm and assured that everyone is alright. Individuals who had to be directed to the safe area should be praised for their willingness to allow the staff to offer safe and private help to the individual who was experiencing the behavioral 'crisis'."</p> <p>The QIDP was interviewed on 10/15/14 at 4:25 PM and indicated there had not been a formal IDT meeting after each incident of client A's behavioral outbursts, but stated, she and the behavior consultant had been "constantly" on the phone with group home staff. She stated, "We transport him separately now...only if there is precursor behavior, and 'He'll let us know" by statements such as "I don't want to go on the van, for example. I transported him myself 8-10 times in the past to protect him." She indicated she talked to client D daily as client A would target client D and stated, "He will let me know if he is concerned. We rehearse the safety plan and I encourage him to listen to staff. "</p> <p>The QIDP was interviewed on 10/16/14 at 11:55 AM and indicated client A's behavior had increased in frequency, his</p>						

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	<p>cycles of maladaptive behavior were occurring closer together and increasing in intensity and severity.</p> <p>The facility's Policy on Protection of Service Recipient From Abuse and Neglect dated 9/2006 was reviewed on 10/14/14 at 4:15 PM and indicated "No employee shall abuse, neglect, exploit, or mistreat an individual or violate the rights of an individual receiving services at Hopewell Center of by their inaction allow abuse, neglect, exploitation or violation of rights."</p> <p>This federal tag relates to complaint #IN00156363.</p> <p>9-3-2(a)</p>			

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W000252	<p>483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. Based upon record review and interview, the facility failed for 1 of 4 sampled clients (client A) to ensure behavior program data was documented.</p> <p>Findings included:</p> <p>Client A's records were reviewed on 10/14/14 at 3:15 PM. Interdisciplinary meeting notes dated 10/7/14 indicated the psychiatrist had discontinued client A's 300 mg (milligrams) Seroquel and started 100 mg Seroquel due to sedation. The notes indicated client A's ER visits on 9/6/14, 9/7/14 and a visit to the psychiatrist on 9/4/14 indicated client A's Clozaril (anti-psychotic) could not be started due to lab results. Client A had 15 incidents of agitation in July (2014), 2 in August, and "?" (sic) in September. Client A had 12 physical aggression incidents for July, 2 in August and "?" (sic) for September.</p> <p>The QIDP was interviewed on 10/14/14 at 4:00 PM. When asked about the question marks for September, 2014 for client A's behavior data, she stated</p>	W000252	To assure compliance with W252, data collection system for Client A has been revised. New data collection system (Attachment D) implements a time sampling method to better track and provide for clearer snap shot of Client A's high frequency behaviors. Staff to receive training on new data collection system 11-17-14. Persons Responsible: Behavior Clinician and QIDP To assure future compliance with W252 for all residents, facility to implement time sampling behavior data collection system for any resident who is exhibiting high frequency behaviors and this system is deemed appropriate by IDT. Persons Responsible: Behavior Clinician and QIDP	11/17/2014
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W000310	<p>behavior rates were missing for September as "It was kind of survival mode to keep everyone safe," and indicated training and behavior data were not recorded in September, 2014 due to staff's time and involvement in managing client A's behavior.</p> <p>This federal tag relates to complaint #IN00156363.</p> <p>9-3-4(a)</p> <p>483.450(e)(1) DRUG USAGE The facility must not use drugs in doses that interfere with the individual client's daily living activities. Based upon record review and interview, the facility failed for 1 of 4 sampled clients (client A) to ensure his medications did not interfere with his ability to function during daily living activities.</p> <p>Findings include:</p>	W000310	To assure compliance with W310 for Client A and all other residents of facility, facility to implement revised medication procedure. Procedure to apply to new medication orders or increases of current orders. Upon administering new medication or new dosage of medication, if staff observe lethargy or impediment of daily activities persisting across a 24 hr period, facility nurse to be	11/17/2014

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	<p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 10/14/14 at 2:32 PM and included the following:</p> <p>A BDDS report dated 7/17/14 indicated client A was found with a contusion to his chest 1/8 inch wide and 3 and 1/2 inches long. Client A was unable to indicate the cause of the injury. An investigation indicated increased drowsiness since beginning Seroquel on 7/9/14 and the medication was reduced on 7/18/14. The investigation indicated the origin of the injury was "inconclusive" and corrective action indicated client A was sleeping downstairs temporarily so that staff can monitor him more closely.</p> <p>A BDDS report dated 7/19/14 indicated staff heard a noise and found client A had fallen out of bed causing a bloody nose and a raised 1 inch abrasion over his right eyebrow. Corrective action indicated client A would be monitored hourly.</p> <p>A BDDS report dated 9/7/14 indicated client A was taken to the ER (emergency room) after "extreme" aggression, physical aggression, and exhibiting "mania." Client A was given a Geodon 20 mg injection at the hospital, and was denied admission. The report indicated</p>		<p>contacted. Facility nurse to perform assessment of resident status, assessment to include newly designed "Medication Evaluation" form (Attachment E) Assessment will be completed through observation and interview of resident, interview with staff and review of staff notes. Once medication evaluation is complete, facility nurse to determine significance of sedation level. If determined that sedation is significant and impeding activities of daily living, nurse will give orders to with hold next dose(s) of potentially sedating medication until physician can be contacted with sedation concerns and provide further recommendations. Staff training on revised medication protocol to be 11-17-14 Persons Responsible: Facility Nurse and QIPD</p>		

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	<p>client A had gone to the ER on 9/6/14 due to "extreme" aggression and given an injection of Ativan 2 mg and prescribed Ativan 1 mg three times daily which was administered on 9/6/14 and 9/7/14. After returning from the ER on 9/6/14, client A threw objects, bit staff and didn't sleep through the night. Client A was restrained 3 times during the night due to his attempt to injure others. Client A slept 1-2 hours and upon awakening, client A immediately became aggressive again. Client A was restrained during the incident and then taken to the ER again on 9/7/14. The report indicated client A was not injured during the restraint. Corrective action indicated client A should follow up with his psychiatrist on 9/8/14. Client A's psychiatrist decreased client A's Ativan and increased client A's Seroquel from 100 mg to 300 mg and added Seroquel 100 mg at 3:00 PM. "Additional staff hours have been added to the schedule to assure safety."</p> <p>Client A's psychiatrist's visits documentation records were reviewed on 10/14/14 at 3:55 PM and indicated client A was seen on 7/29/14. Client A "has been oversedated (sic) by Seroquel 100 mg qAM (every morning) and 300 mg qhs (at bedtime). He fell out of bed several times and injured his face. He fell asleep at meal time. His family doctor</p>						

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W000407	<p>stopped the 300 mg dose and gave the 100 mg dose at bedtime. This has worked well for several days with good behavior, adequate sleep and he is able to stay awake in the daytime." The recommendation indicated "stop Seroquel 300 mg continue Seroquel 100 mg qhs."</p> <p>Staff #4 was interviewed on 10/14/14 at 5:35 PM. He stated "Three weeks ago, when they got him (client A) on Seroquel, it helped tremendously with aggression, but now he is sleepy and he's not able to do a lot of stuff. Right before that we weren't able to function as a group home (due to client A's behavior) and [client A] had 1:1 (one to one) to staff for awhile for 1 and 1/1 to 2 weeks."</p> <p>This federal tag relates to complaint #IN00156363.</p> <p>9-3-5(a)</p> <p>483.470(a)(1) CLIENT LIVING ENVIRONMENT The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to</p>						

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	<p>promote the growth and development of all those housed together.</p> <p>Based on record review and interview for 1 of 4 sampled clients (client A), the facility failed to ensure client A resided in a setting which met the client's identified behavioral and psychiatric needs.</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 10/14/14 at 2:32 PM and included the following:</p> <p>A BDDS report dated 7/5/14 indicated client A "attempted to go forcefully toward another housemate. Staff stepped between the two. [Client A] then went downstairs to that housemate's room and threw his TV off of the stand and began throwing that housemate's belongings." Client A "charged at the staff, hit staff in eye (sic) and forehead and scratched several times." Staff prompted other residents to go to their rooms per the "Behavior Crisis Plan." Corrective action indicated client A's medication had been changed in April, 2014 from Zyprexa (bi-polar) to Ability (bi-polar). Client A's "behavior had improved for a time, but agitation and aggression have been escalating over the past several weeks." Client A had rescheduled his appointment on 6/25/14 to 7/23/14 due to the psychiatrist's illness. "Staff will follow [client A's] behavior plan and Behavior Response Plan."</p> <p>A BDDS report dated 7/17/14 indicated client A was found with a contusion to his chest 1/8 inch wide and 3 and 1/2 inches long. Client A was unable to indicate the cause of the injury. An investigation indicated increased drowsiness since</p>	W000407	To assure compliance with W407, facility also agrees that after serving Client A for more than 20 years, facility can no longer meet his behavioral and psychiatric needs. As part of this decision, facility has taken the following action steps to find alternative placement for Client A. 9-8-14 Facility administrator contacted Lori Fine, BDDS District 6 Manager and informed that Hopewell Center could no longer serve Client A in current group home placement. 9-15-14 Bethany Hilty, BDDS service coordinator met with facility QIDP and Client A. At this meeting Client A stated that he would like to move out of the group home and move into an apartment with a couple of housemates. 9-17-14 Confirmation of Diagnoses form delivered to Client A's physician for completion. 10-2-14 Completed Confirmation of Diagnoses form returned to BDDS office. 10-17-14 BDDS office emailed Freedom of Choice form for Client A to confirm he wanted to chose community and home based waiver services. Client A selected waiver services and form was returned. 10-27-14 BDDS office contacted facility stating Client A had been approved for home and community based waiver services. Additionally, service coordinator sent case	11/19/2014	

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	<p>beginning Seroquel on 7/9/14 and the medication was reduced on 7/18/14. The investigation indicated the origin of the injury was "inconclusive" and corrective action indicated client A was sleeping downstairs temporarily so that staff can monitor him more closely.</p> <p>A BDDS report dated 7/19/14 indicated staff heard a noise and found client A had fallen out of bed causing a bloody nose and a raised 1 inch abrasion over his right eyebrow. Corrective action indicated client A would be monitored hourly.</p> <p>A BDDS report dated 8/31/14 indicated client A threw a laundry basket at client D and hit him in the knee. Staff stepped between the clients and prompted client A to stop the behavior. Client A was asked to go to his room and he refused. "A two person escort was attempted by staff to [client A's] room. [Client A] scratched staff and spit in staff's face. [Client A] then kicked staff in the shin and punched staff in the shoulder. [Client A's] agitation continued with yelling, threatening and throwing items. Staff phoned the residential nurse who approved the administration of Ativan (anti-anxiety) 2 mg (milligrams). Corrective action indicated client A was in "a manic cycle of his bi-polar mood disorder." Staff were to continue to follow client A's behavior plan and the nurse had left a message with client A's psychiatrist regarding the incident on 9/2/14 "awaiting call back." The report indicated client D was not injured during the incident.</p> <p>A BDDS report dated 9/1/14 indicated client A had thrown stationary bicycle pedals at staff, threw trash cans, knocked off a roommate's belongings and a game system off his dresser, and threatened harm to others. Client A was asked to go to his room, but client A refused and continued walking through the house "yelling and</p>		<p>management pick list for Client A to chose a case management company. Client A chose IPMG and signed pick list was returned to BDDS office. 10-30-14 IPMG intake coordinator contacted facility QIDP requesting programming and medical information for Client A. Information was sent as requested. 11-4-14 IPMG intake coordinator, facility QIDP, Client A and his mother met together to discuss needs, desires etc. Client A's mother expressed her desire to find waiver placement as near the Anderson area as possible. Case manager indicated there were several waiver providers in Anderson/Muncie area and that he would contact them to see if any were interested in interviewing with Client A for potential placement. 11-10-14 Facility contacted by a residential provider who has several openings in waiver sites in the central Indiana area. Meeting set to interview Client A on 11-11-14. 11-11-14 New provider met with Client A and also interviewed facility QIDP and nurse. New provideer indicted they would like to serve Client A and will set up a home visit for Client A and his mother to visit the potential waiver site within next few days.</p>		

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	<p>threatening." Staff called the nurse and obtained approval to administer 2 mg (milligrams) prn (as needed) Ativan. The report indicated the facility's staff were awaiting a call from the psychiatrist's office regarding client A's behavior.</p> <p>A BDDS report dated 9/3/14 indicated client A refused to put on a seat belt and "grabbed the staff's arm, hit off staff's glasses and spit in staff's face. Other clients were asked to get off the van and were transported home by another staff. [Client A] continued agitation of yelling and threatening. Ativan was given at 4:00 PM. [Client A's] behavior did not de-escalate throughout the evening. [Client A] continued agitation of yelling and threatening. Ativan 2 mg was given at 8 PM also." Corrective action indicated client A saw the psychiatrist on 9/4/14 and Clozaril (schizophrenia) was added as well as Ativan at 3 PM and 7 PM. "Staff will continue to monitor behavior and follow behavior plan."</p> <p>A BDDS report dated 9/7/14 indicated client A was taken to the ER (emergency room) after "extreme" aggression, physical aggression, and exhibiting "mania." Client A was given a Geodon 20 mg injection at the hospital, and was denied admission. The report indicated client A had gone to the ER on 9/6/14 due to "extreme" aggression and given an injection of Ativan 2 mg and prescribed Ativan 1 mg three times daily which was administered on 9/6/14 and 9/7/14. After returning from the ER on 9/6/14, client A threw objects, bit staff and didn't sleep through the night. Client A was restrained 3 times during the night due to his attempt to injure others. Client A slept 1-2 hours and upon awakening, client A immediately became aggressive again. Client A was restrained during the incident and then taken to the ER again on 9/7/14. The report indicated client A was not injured during the restraint.</p>			

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	<p>Corrective action indicated client A should follow up with his psychiatrist on 9/8/14. Client A's psychiatrist decreased client A's Ativan and increased client A's Seroquel from 100 mg to 300 mg and added Seroquel 100 mg at 3:00 PM. "Additional staff hours have been added to the schedule to assure safety."</p> <p>A BDDS report dated 9/9/14 indicated client A was yelling and threatening staff and attempted to hit staff. Twice during the incident a two person hold was implemented and client A was released within 10 minutes. Client A was not injured during the restraint. Corrective action indicated client A's psychiatrist increased client A's Seroquel.</p> <p>A BDDS report dated 9/15/14 indicated client A hit client C in the back while in the van with "no precipitating event." The report indicated client C was transported separately. Corrective action indicated "staff are consistently attempting to calm [client A] during his continued cycle of his bi-polar mood disorder. Corrective action indicated client A was to be transported separately from workshop on days when he threatened harm to other housemates. The report injured indicated client C was not injured.</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 10/14/14 at 3:14 PM. She indicated client A used to have periods of stability in behavior, and stated but "those episodes (of stable behavior) have decreased in duration. September was a constant "episode of physically aggressive behavior and the facility was seeking alternative placement for him. She indicated level of care had just been obtained for client A as part of the process to find alternate placement. She stated "His mental health needs have superceded other treatment," and indicated</p>						

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	<p>client A was not able to participate in goals (training)." She stated "We try to keep clients and [client A] separated during episodes."</p> <p>Client A's records were reviewed on 10/14/14 at 3:15 PM. A Behavior Improvement Program dated 7/7/14 indicated target objectives of agitation (yelling, screaming, swearing, making negative or accusatory comments directed towards others, calling others' names, slamming doors, throwing items, and/or threatening to run away or harm others), physical aggression (harming or attempting to harm others, primarily hitting, kicking, shoving, and/or throwing objects at others, property destruction (damaging or attempting to damage property, primarily hitting, throwing, or knocking over items, objects or furniture) and making false statements (false accusations or saying things that are not true in order to gain desired attention and responses by others). The plan indicated "Most of [client A's] physical aggression appear to be secondary to his underlying mood disorder. Documentation and observation have indicated that [client A] has periods of time when he becomes extremely 'depressed.' During these times, [client] A becomes tired, withdrawn, non-responsive and does not interact with others. [Client A] also has periods of time where he appears to become 'manic.' During these times, he exhibits pressured speech, increased psychomotor activity, frequent episodes of irritability and agitation, and physical aggression directed toward staff and his housemates. Psychotropic medication has significantly helped to reduce the frequency of these cycles, but they do still occur, and the 'manic' cycles in particular are quite difficult to manage...Medications have continued to be adjusted in attempts of gaining better behavioral control. At times, [client A's] displays of aggression present a significant risk to those</p>						

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	<p>around him. Subsequently it is at times, necessary to utilize physical containment procedures to keep others in [client A's] vicinity safe. Historically, it has also been necessary to use a PRN medication if [client A] escalates to the extent that implementation of a manual restraint is deemed a safety concern, or when he continues to escalate and fails to calm.... " The plan indicated a revision to his behavior program dated 7/5/14 indicating client A "has continued to struggle with extremely challenging behavior over the last year. He was taken to the emergency room earlier in the year, and a myriad of different medications have been attempted in an effort of decreasing his mood cycles. When these occur, [client A] becomes extremely agitated, aggressive, and destructive of property. On July 5, 2014, [client A] became out of control. He threw a television, charged after a staff, hit them in the face, then repeatedly struck and scratched them. He was administered an Ativan PRN to assist in calming down. The day before that, [client A] ripped a fire extinguisher off the wall. [Client A's] behavior is volatile, unpredictable, and has the potential to cause harm or injury to others. Restraint procedures, criteria for PRN usage, and the safe storage of knives and other sharp objects are all outlined in the current behavior program....."</p> <p>IDT (Interdisciplinary Team) meetings documentation and related staff training records were reviewed on 10/14/14 at 3:28 PM and included the following:</p> <p>Meeting notes dated 7/15/14 indicated client A had discontinued Zyprexa on 4/7/14 and started Abilify. The notes indicated client A had 1 incident of agitation in April (2014), 4 in May, and 5 in June. Client A had 1 incident of physical aggression in April, 4 incidents in May, and 5 in June. The behavior specialist indicated client A's</p>						

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	<p>plan had been modified and indicated "rapid cycling. Staff training 7/28/14. Discussed transition plan when comes home from [relative's]...."</p> <p>Meeting notes dated 10/7/14 indicated the psychiatrist had discontinued client A's 300 mg Seroquel and started 100 mg Seroquel due to sedation. The notes indicated client A's ER visits on 9/6/14, 9/7/14 and a visit to the psychiatrist on 9/4/14 indicated client A's Clozaril could not be started due to lab results. Client A had 15 incidents of agitation in July (2014), 2 in August, and "?" (sic) in September. Client A had 12 physical aggression incidents for July, 2 in August and "?" (sic) for September.</p> <p>A Behavior Plan Training/Review dated 10/6/14 indicated staff had been trained on all client behavior plans at the group home.</p> <p>A letter dated 9/11/14 from the behavior specialist to the psychiatrist was reviewed on 10/14/14 at 3:45 PM and indicated "As you know, our client [client A], has been struggling with extremely high intensity agitated, aggressive and destructive behaviors over the last several weeks. I know that medication changes are occurring, and we are all hopeful that his apparent manic cycle will end soon. The letter indicated client A had "become so out of control, that he had to be physically restrained on several occasions," and indicated on 9/7/14 staff had spent "over 6 hours with him at the Emergency Room ...Our intent was to get him admitted to [hospital #1], as we really felt that it was unsafe to continue trying to have [client A] remain at the group home. Unfortunately, even though the staff at [hospital #2] strongly felt [client A] should have been admitted to the Psychiatric Unit at [hospital #1], this did not occur, as the doctor from [hospital #1] denied his</p>			

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	<p>admission. Subsequently, the [hospital #2] ER staff then attempted to get [client A] admitted to the [hospital #3], however, this was also denied. I would like to have a 'plan' in place for staff to follow to ensure their and [client A's] safety should this situation re-occur. Do you have any suggestions as to what steps staff should take if we again feel that [client A's] behavior is so out of control hat (sic) he cannot be safely maintained....?"</p> <p>Client A's psychiatrist's visits documentation records were reviewed on 10/14/14 at 3:55 PM and indicated client A was seen on 7/29/14. Client A "has been oversedated (sic) by Seroquel 100 mg qAM (every morning) and 300 mg qhs (at bedtime). He fell out of bed several times and injured his face. He fell asleep at meal time. His family doctor stopped the 300 mg dose and gave the 100 mg dose at bedtime. This has worked well for several days with good behavior, adequate sleep and he is able to stay awake in the daytime." The recommendation indicated "stop Seroquel 300 mg continue Seroquel 100 mg qhs. Visit notes dated 9/4/14 indicated "has been much more agitated fighting with staff and peers. Throwing chairs, breaking things. This has been progressively worse over the last few years. Will start clozapine for agitation...." A visit note dated 10/2/14 indicated client A "is a little sedated by his medicines. He is still verbally abusive but has stopped being physically aggressive since his medications were increased. This is an improvement but not ideal. I don't want to increase his medicines further due to sedation but he could do better with behavior and mood stability." The note indicated client A's labs would be reviewed again and client A's Tegretol may be stopped and clozapine considered depending upon client A's lab results.</p>			

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	<p>The QIDP was interviewed again on 10/14/14 at 4:00 PM and indicated the behavior specialist had written a letter to the psychiatrist to ask about additional steps to take to protect clients in the home during client A's behavioral episodes. She indicated there had been fewer incidents currently than there were in September, 2014, but indicated since client A had refused to put a seat belt on prior to leaving after workshop that day, his refusal may indicate the start of escalating behavior. She indicated if client A's behavior escalated the plan included staff were to call the on call staff, and clients were removed from the area. She stated in regards to client A's behavior in September, "It was kind of survival mode to keep everyone safe."</p> <p>Observations were completed at the group home on 10/14/14 from 5:09 PM until 6:03 PM. Client B opened the door, then went in his bedroom. Client A sat in the living room in a chair and periodically uttered words that were not understood by the surveyor. Client F assisted staff #4 prepare dinner and client D set the table after watching TV. Client C sat at the kitchen table with client D watching client F and staff #4 in the kitchen prior to receiving his medications. Client G played basketball. Client E remained in his bedroom lying on his bed during the observation. Staff #3 recorded documentation and completed medication administration while staff #6 administered treatments for clients B and E. None of the clients interacted with client A during the observation.</p> <p>Staff #3 was interviewed on 10/14/14 at 5:10 PM. When asked about client A, he stated, "It's difficult to manage him; throwing, breaking objects, endangered other clients safety, verbal aggression and threats to clients and staff." He indicated client A had hit other staff and clients.</p>				

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	<p>He stated staff were able to prevent client A from hitting other clients "most of the time," and "every now and then he was able to hit clients, but caused no real harm." Staff #3 indicated client #3 was more calm due to the medications he was now taking, and stated, if not for the medications, "He would be his old self." He stated just prior to the surveyor's arrival, client A had become "very verbal" regarding his bed sheets regarding washing them, but staff had addressed his concerns and client A had calmed. He indicated client A would sometimes refuse to wear his seatbelt and stated, "Sometimes we'll wait him out and take some guys home first." He indicated client A was seated near the back of the van away from clients to protect clients. He indicated the plan to address client A's behavior included encouraging clients to go to other areas of the house when client A's behavior escalated to protect them from physical aggression. Client A was to be encouraged to go to a quiet area when physically aggressive until calm. He indicated the staff then encouraged the clients to go about their day as usual. When asked if clients were safe in the home, he stated, "At this point they are safe. Without medication (for client A), No." He indicated client A was stable at this time and stated when client A had behaviors in the past, "It was hard to do active treatment with the other guys and we had to address [client A's] aggression."</p> <p>Client D was interviewed on 10/14/14 at 5:25 PM. When asked if he felt safe living in the group home, he indicated he did worry about client A and stated, "He's hard to handle. I don't want to talk about it too much." He stated, he had been pushed down the stairs "really hard" by client A, but had not fallen. He stated he thought it had occurred "about two weeks ago," but was unable to provide a date or further details other than to</p>			

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	<p>indicate staff had intervened. He indicated he was fearful of client but stated, "staff keep me safe," and "I feel safe halfway."</p> <p>Staff #4 was interviewed on 10/14/14 at 5:35 PM. He stated client A "Got into a groove of being aggressive all of the time. He usually cycles in and out, but last month didn't cycle out. A couple of times he had to be restrained and guided to another room. He was picking up large objects and throwing them; chairs, pedal and a fire extinguisher. Three weeks ago, when they got him on Seroquel, it helped tremendously with aggression, but now he is sleepy and he's not able to do a lot of stuff. Right before that we weren't able to function as a group home (due to client A's behavior) and client A had 1:1 (one to one) staff for awhile for 1 and 1/1 to 2 weeks." He indicated the medication had helped client A. Staff #4 indicated client A had thrown flower pots outside at his car and damaged it. During the interview, a thud was heard in the living room where client A was sitting and staff #4 ran to check on him. He stated, "Oh good [staff #3] has him," and indicated he had been concerned client A had exhibited physical aggression when he heard the noise.</p> <p>Staff #3 approached the surveyor on 10/14/14 at 6:00 PM and stated, "Just so you know, [client A] got upset earlier and stated, 'I'm not answering any questions,' and got up and threw a bike pedal. I went behind him to make sure he is relaxing in his room." He indicated client A had his own room and the thud that was heard during the interview with staff #3 was client A throwing the pedal. He indicated he placed the bike pedal in another room away from easy access to client A and no clients had been near him when he threw the pedal. Staff #3 showed the surveyor the bike pedal on a stand in an adjacent room to the living</p>						

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	<p>room where client A had been seated.</p> <p>A Behavioral Crisis Response Plan dated 2/10/14 indicated "In the event that [client A] becomes agitated, staff should follow steps 1-6 of his behavior plan to prompt with step 6 being a 2 person escort to his room. In the event that [client A] demonstrates escalation behavior which is likely to become or does become aggressive or destructive in nature, all other residents of the home should be directed to a designated safe area away from him. Safe areas may include: the garage, or an adjacent room which has a door to serve as a 'partition' between the potentially aggressive individual and other individuals. Though it will likely be necessary for all available staff to assist in the safe de-escalation, and if necessary, containment of the individual who has become extremely agitated and/or aggressive, attempts to move to the area the other individuals have been directed to in order to visually check and verbally calm and encourage (sic) should occur. Once the 'crisis' situation has been successfully defused, de-briefing between staff members and other housemates should occur to help ensure others who had to move to a safe area now feel calm and assured that everyone is alright. Individuals who had to be directed to the safe area should be praised for their willingness to allow the staff to offer safe and private help to the individual who was experiencing the behavioral 'crisis'."</p> <p>The QIDP was interviewed on 10/16/14 at 11:55 AM and indicated client A's behavior had increased in frequency, his cycles of maladaptive behavior were occurring closer together and increasing in intensity and severity. She indicated client A would be better served in another setting to address his mental health needs.</p>						

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	<p>The Community Services Director was interviewed on 10/20/14 at 1:52 PM and indicated client A had been referred for alternate placement 5 to 6 weeks ago and he had just been assessed for his level of care needs as part of the process for alternate placement.</p> <p>This federal tag relates to complaint #IN00156363.</p> <p>9-3-7(a)</p>						