

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G750	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/11/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 60680 LILAC RD SOUTH BEND, IN 46614
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W 0000 Bldg. 00	<p>This visit was for the investigation of complaint #IN00176027.</p> <p>Complaint #IN00176027: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W149, W154 and W331.</p> <p>Survey dates: 7/30, 8/4, 8/5 and 8/11/15.</p> <p>Facility Number: 011765 Provider Number: 15G750 AIM Number: 200908290</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0149 Bldg. 00	<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 interview and record review for 1 of 2 sampled clients (A), the facility failed to implement its written policy and procedures to prevent neglect of a client in regard to the use of an unapproved restraint technique. The facility failed to implement its written policies and procedures in regard to conducting a thorough investigation which included</p>	W 0149	The Area Director and Program Director have reviewed this deficiency and are completing re-training on the expectation that any investigation of an unapproved restraint must include a review of any potential injury to the individual served. While the staff had completed the body check and documented the injuries and the Program Director had requested that the nurse	09/10/2015

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>any injuries in regard to the use of the restraint, and/or to ensure the client was physically assessed for injuries after the use of an unapproved restraint.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 8/4/15 at 12:30 PM. The facility's 6/16/15 (sic) reportable incident report indicated "On 6-17-2015 (sic), [client A] arrived at [name of workshop] planning to attend his [name of program]. Unfortunately, the staff were not supposed to bring [client A] as his behavioral consultants were unable to be here and per his IDT (interdisciplinary team) they will accompany [client A] to [name of program] while he acclimates to his volunteer work at [name of workshop]. [Client A] did not come to Day Program with any of the things he needed; his lunch, his drink for break time, or his glucometer (measures blood sugar level). [Name of workshop] Program Manager, [workshop staff #1] attempted to call [client A's] behavioral consultant when she realized he had come into programming at 8:47 AM. The Dungarvin behavior consultant was frustrated as she felt it had been communicated to staff members that he should not attend today. She said the</p>		<p>come to see the individual to assess the injury, the Program Director failed to include this information in the summary of the investigation. In addition, all staff at the facility have or are receiving re-training on the definition of an unapproved restraint as it relates to the Dungarvin Policy on Abuse, Neglect, and Exploitation. They are also receiving re-training on the importance of checking the individuals for any potential injury after the use of an approved or unapproved restraint. The team for Client A did meet after the incident in question, as one of the day services staff members was involved in the unapproved restraint. The team clarified the parameters of the behavior support program for Client A and techniques that are and are not approved by the team for use in emergency situations. Subsequently, Client A did have another outburst at day services, but the staff member did not use any physical restraint. Due to this recurrent behavior, Client A has been discharged from the day service provider and his team is meeting on 9/10 to develop additional programs to meet his vocational needs going forward. Going forward, the Area Director will be responsible to verify that all pertinent information, including the extent of injury to an individual, is included in investigation summaries.</p>	

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	<p>soonest she could arrive was 30 minutes. Then, [workshop staff #2] informed [workshop staff #1] that he did not have his needed supplies. [Workshop staff #2] called the Dungarvin group home manager, [staff #1], and requested that staff come back and pick up [client A]. [Staff #1] responded that he would send them back. At 9:12 AM, when staff let [client A] know that his staff were on their way back to get him, [client A] screamed and turned over the coffee table in front of him. He got up and ran out of the building and into the parking lot. The [name of workshop staff] working with him, [workshop staff #2], followed him out the door and tried to keep him safe from traffic and from going into the street. [Workshop staff #1] [name of workshop] Program Manager and [administrative staff #2], Director of Family and Community Supports followed [client A] and the staff (workshop staff #2) out the door (sic) were ready to intervene if [client A] went out into the busy street. [Client A] walked around the building and went back inside where he continued to rage in the lobby. He threw items; he swept items off the receptionist's desk, screamed, swore, called names, slapped, hit and kicked staff members. [Name of day program staff] reported that Dungarvin staff backed him up to the</p>			

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	<p>counter, held his wrists, forearms, calves and ankles. [Client A] ended up lying on the receptionist's counter. [Client A] continued to hit and kick his staff persons. The Dungarvin staff requested assistance from the [name of day program] staff and [workshop staff #2] went to stabilize [client A] on the counter to prevent him from re injuring (sic) his ankle or falling from the counter to the floor and provided assistance to the Dungarvin staff. Dungarvin and [name of day program] staff members were holding [client A] and three staff members carried him from the counter further out into the lobby. [Client A] was fighting, spitting, cursing, and trying to break free. Two staff persons lifted him from each shoulder, and one staff lifted his legs above the ankle. [Workshop staff #1] and [administrative staff #2] were positioned outside to intervene if [client A] went out to the road again. [Name of workshop staff #1], [name of Day Program] Program Manager called [behavior consultant #1] and let her know what was happening, as I was on the phone with her, I turned and saw the staff carrying [client A]. When I saw this was happening, I pointed it out to my director she went inside and told the staff we at [name of workshop] do not carry people who are upset. She requested that the [name of workshop] staff put [client A]</p>			

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	<p>down. He (workshop staff #2) lowered [client A] to the floor and backed away. Some staff members stepped in and held his (client A's) arms and legs while he was struggling on the floor. They attempted to calm him using soothing words; he remained very agitated. After some time a Dungarvin staff who had better rapport with [client A] arrived at [name of workshop]. In just a few minutes, he was able to put [client A] at ease a little bit and [client A] agreed to leave with him. [Client A] was assisted to stand up off the floor and he walked out to Dungarvin's van. [Name of workshop] could not assess [client A] for injury at that time...."</p> <p>The facility's 6/29/15 follow-up report to the 6/17/15 (sic) reportable incident report indicated client A was not injured. The follow-up report also indicated "The above named staff (staff #2 and staff #3) were both responsible for making sure that the individual had his essentials. The information to not drop (take to day program) the individual was not communicated via email and the two staff who dropped the individual was (sic) not aware that the individual was (sic) not supposed to be at day program that day...."</p> <p>The facility's 6/19/15 - 6/23/15</p>			

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	<p>Investigation Report indicated staff #2 and #3 were suspended in regard to an allegation of the use of an unauthorized restraint. The facility's investigation indicated the workshop staff and staff #2 indicated client A was lifted/carried by staff. The investigation indicated staff #3 indicated client A was not lifted/carried during the restraint. The facility's 6/23/15 investigation indicated "...The investigation statements show that both [staff #3] and [staff #2], attempted to do an approved two person hold or restraint to prevent [client A] from injuring himself but it was unsuccessful. Each staff demonstrated to the Program Director when giving their statements. The technique which was shown by a pull through first by placing the hand above the wrist, bending the arm into a 'C' formation, with the palm facing up over my stomach while the other arm was on my shoulder with the thumb in the arm pit. From the evidence provided, it is clear that [client A] was transferred from the front desk at [name of workshop] to an open area in front of the reception desk, by lifting..." The facility's 6/23/15 investigative report indicated "...Based on the evidence provided the allegation of the use of an unauthorized restraint is substantiated even though the intention to move [client A], as can drawn from the witness statements, was to protect him</p>			

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	<p>from harm (sic). VI. Actions: It is the recommendation of this investigator that [staff #2] should be retrained on DCI (Dungarvin Crisis Intervention) and be reinstated on a 90 day probation basis. Due to [staff #3's] withholding of information and changing his statements, as well as secondary information obtained during the investigation, including his decision to log into Therap (facility's computerized record system) to complete documentation from a personal computer after having been placed on suspension, it is recommended that his employment be terminated." The facility's investigation failed to indicate client A was checked/assessed for injuries after the use of the 6/16/15 unapproved restraint technique.</p> <p>Client A's record was reviewed on 8/4/15 at 1:18 PM. Client A's 6/18/15 T (Therap-facility's computer system)-Log progress note indicated "[Client A] has a scratch mark 5cm (centimeters) long and Bruise mark half size of a palm. He is not complaining of any pain, or does not itch...Nurse will be coming to do another observation." Client A's 6/18/15 note did not indicate how client A received the scratch/bruise. Client A's 6/18/15 T-Log also did not indicate where the injuries were found on client A. Client A's T-Logs from 6/1/15 to 8/4/15 and the</p>			

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	<p>client's computerized record system, indicated the facility failed to assess and/or document an assessment of client A's injuries.</p> <p>Client A's 4/15/15 updated Behavioral Support Plan (BSP) indicated client A demonstrated physical aggression defined as "shaking his fist" at others, hitting others, chasing others, pushing, kicking, slapping, knocking down, using weapons and throwing of objects. Client A's BSP indicated If [client A] engages in physical aggression after being prompted 1 time, residential staff should then follow the Hierarchy of Physical Interaction of DCI Techniques listed below, using only the 'Hands On Escorting' technique. Other clients should be removed from the vicinity if [client A] engages in physical aggression. f. If this occurs at [name of workshop], staff should employ [name of workshop] approved Mandt technique to address physical aggression. If [client A] does not stop the physical aggression after being prompted, staff should implement the [name of workshop] approved and trained Mandt Intervention Technique...." Client A's plan indicated facility staff could utilize "Physical Redirection/Response Blocking, Releasing, Walking with or accompanying/Escorting, Side Body Hug, One Arm Standing, and Hands on</p>			

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	<p>Escorting (two person escort)." Client A's BSP did not indicate client A should be carried when restrained.</p> <p>Interview with staff #5 on 7/30/15 at 6:03 PM indicated when asked if client A required the use of restraints, stated "We are able to talk him down." Staff #5 indicated client A was recently restrained 1 time at the day program.</p> <p>Interview with staff #4 on 7/30/15 at 6:07 PM indicated when asked how often client A had to be restrained, stated "He has never been restrained when I'm here." When asked if clients could be carried as a restraint, staff #4 stated "No." Staff #4 indicated client A would only be restrained if he tried to get into the road.</p> <p>Interview with staff #6 on 7/30/15 at 6:32 PM stated client A "Normally don't require restraints." Staff #6 indicated facility staff would talk to client A and he would calm himself down. Staff #6 indicated client A attended workshop 2 days a week for 2 hours.</p> <p>Interview with the Program Director (PD) on 8/4/15 at 2:44 PM and by email on 8/5/15 at 10:54 AM indicated staff #2 and #3 did not utilize an approved Dungarvin restraint technique on 6/16/15. The PD stated the facility should have</p>			

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	<p>utilized a "Two person assist as a last resort" to move client A. The PD stated "Lifting" was not part of the staffs' training. The PD indicated the staff were trying to prevent client A from injuring his ankle. The PD indicated client A had been off work for 6 months due to a previous ankle injury which required surgery. The PD indicated staff #2 was retrained in regard to the DCI techniques and on abuse and neglect. The PD indicated staff #3 was released from his employment as the staff indicated he did not lift client A, and accessed the facility's Therap program after the staff had been suspended for the 6/16/15 allegation of abuse/neglect. When asked how client A received the scratch and bruise, the PD stated "Could have been from day program incident." The PD indicated the facility's nurse was on leave at the time of the incident. The PD indicated the on-call nurse would have assessed client A for any injuries. The PD indicated the nurse's assessment of client A's injuries should have been in the T-logs. The PD did not provide any additional information and/or documentation in regard to an assessment of client A's injuries. The PD indicated the facility's investigation did not indicate and/or address client A's injuries.</p> <p>The facility's policy and procedures were</p>			

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W 0154 Bldg. 00	<p>reviewed on 8/4/15 at 11:52 AM. The facility's 6/1/15 Policy and Procedure Concerning Abuse, Neglect and Exploitation indicated "Dungarvin believes that each individual has the right to be free from mental, emotional and physical abuse in his/her daily life...Physical abuse is defined as any ...Unnecessary restraint/confinement resulting from physical intervention that limits the movement or mobility of an individual that is not outlined in an individual's behavior support plan...Neglect is defined as failure to provide appropriate care, supervision or training, failure to provide food and medical services as needed,..." The facility's 6/1/15 policy indicated the facility would thoroughly investigate all allegations of abuse, neglect and/or injuries of unknown source.</p> <p>This federal tag relates to complaint #IN00176027.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 1 of 3 allegations of abuse, neglect and/or</p>	W 0154	The Area Director and Program Director have reviewed this deficiency and are completing	09/10/2015

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	<p>injuries of unknown source reviewed, the facility failed to conduct a thorough investigation in regard to an allegation of neglect in regard to the use of an unapproved restraint possibly resulting in injury to the client.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and or investigations were reviewed on 8/4/15 at 12:30 PM. The facility's 6/16/15 (sic) reportable incident report indicated "On 6-17-2015, (sic) [client A] arrived at [name of workshop] planning to attend his [name of program]. Unfortunately, the staff were not supposed to bring [client A] as his behavioral consultants were unable to be here and per his IDT (interdisciplinary team) they will accompany [client A] to [name of program] while he acclimates to his volunteer work at [name of workshop]. [Client A] did not come to Day Program with any of the things he needed; his lunch, his drink for break time, or his glucometer (measures blood sugar level). [Name of workshop] Program Manager, [workshop staff #1] attempted to call [client A's] behavioral consultant when she realized he had come into programming at 8:47 AM. The Dungarvin behavior consultant was frustrated as she felt it had been</p>		<p>re-training on the expectation that any investigation of an unapproved restraint must include a review of any potential injury to the individual served. While the staff had completed the body check and documented the injuries and the Program Director had requested that the nurse come to see the individual to assess the injury, the Program Director failed to include this information in the summary of the investigation. Going forward, the Area Director will be responsible to verify that all pertinent information, including the extent of injury to an individual, is included in investigation summaries.</p>	

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	<p>communicated to staff members that he should not attend today. She said the soonest she could arrive was 30 minutes. Then, [workshop staff #2] informed [workshop staff #1] that he did not have his needed supplies. [Workshop staff #2] called the Dugarvin group home manager, [staff #1], and requested that staff come back and pick up [client A]. [Staff #1] responded that he would send them back. At 9:12 AM, when staff let [client A] know that his staff were on their way back to get him, [client A] screamed and turned over the coffee table in front of him. He got up and ran out of the building and into the parking lot. The [name of workshop staff] working with him, [workshop staff #2], followed him out the door and tried to keep him safe from traffic and from going into the street. [Workshop staff #1] [name of workshop] Program Manager and [administrative staff #2], Director of Family and Community Supports followed [client A] and the staff (workshop staff #2) out the door (sic) were ready to intervene if [client A] went out into the busy street. [Client A] walked around the building and went back inside where he continued to rage in the lobby. He threw items; he swept items off the receptionist's desk, screamed, swore, called names, slapped, hit and kicked staff members. [Name of</p>				

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	<p>day program staff] reported that Dungarvin staff backed him up to the counter, held his wrists, forearms, calves and ankles. [Client A] ended up lying on the receptionist's counter. [Client A] continued to hit and kick his staff persons. The Dungarvin staff requested assistance from the [name of day program] staff and [workshop staff #2] went to stabilize [client A] on the counter to prevent him from re injuring (sic) his ankle or falling from the counter to the floor and provided assistance to the Dungarvin staff. Dungarvin and [name of day program] staff members were holding [client A] and three staff members carried him from the counter further out into the lobby. [Client A] was fighting, spitting, cursing, and trying to break free. Two staff persons lifted him from each shoulder, and one staff lifted his legs above the ankle. [Workshop staff #1] and [administrative staff #2] were positioned outside to intervene if [client A] went out to the road again. [Name of workshop staff #1], [name of Day Program] Program Manager called [behavior consultant #1] and let her know what was happening, as I was on the phone with her, I turned and saw the staff carrying [client A]. When I saw this was happening, I pointed it out to my director she went inside and told the staff we at [name of workshop] do not carry people</p>			
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	<p>who are upset. She requested that the [name of workshop] staff put [client A] down. He (workshop staff #2) lowered [client A] to the floor and backed away. Some staff members stepped in and held his (client A's) arms and legs while he was struggling on the floor. They attempted to calm him using soothing words; he remained very agitated. After some time a Dungarvin staff who had better rapport with [client A] arrived at [name of workshop]. In just a few minutes, he was able to put [client A] at ease a little bit and [client A] agreed to leave with him. [Client A] was assisted to stand up off the floor and he walked out to Dungarvin's van. [Name of workshop] could not assess [client A] for injury at that time...."</p> <p>The facility's 6/29/15 follow-up report to the 6/17/15 (sic) reportable incident report indicated client A was not injured. The follow-up report also indicated "The above named staff (staff #2 and staff #3) were both responsible for making sure that the individual had his essentials. The information to not drop (take to day program) the individual was not communicated via email and the two staff who dropped the individual were not aware that the individual were not supposed to be at day program that day...."</p>			
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	<p>The facility's 6/19/15 - 6/23/15 Investigation Report indicated staff #2 and #3 were suspended in regard to an allegation of the use of an unauthorized restraint. The facility's investigation indicated the workshop staff and staff #2 indicated client A was lifted/carried by staff. The investigation indicated staff #3 indicated client A was not lifted/carried during the restraint. The facility's 6/23/15 investigation indicated "...The investigation statements show that both [staff #3] and [staff #2], attempted to do an approved two person hold or restraint to prevent [client A] from injuring himself but it was unsuccessful. Each staff demonstrated to the Program Director when giving their statements. The technique which was shown by a pull through first by placing the hand above the wrist, bending the arm into a 'C' formation, with the palm facing up over my stomach while the other arm was on my shoulder with the thumb in the arm pit. From the evidence provided, it is clear that [client A] was transferred from the front desk at [name of workshop] to an open area in front of the reception desk, by lifting..." The facility's 6/23/15 investigative report indicated "...Based on the evidence provided the allegation of the use of an unauthorized restraint is substantiated even though the intention to</p>			
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	<p>move [client A], as can drawn from the witness statements, was to protect him from harm (sic). VI. Actions: It is the recommendation of this investigator that [staff #2] should be retrained on DCI (Dungarvin Crisis Intervention) and be reinstated on a 90 day probation basis. Due to [staff #3's] withholding of information and changing his statements, as well as secondary information obtained during the investigation, including his decision to log into Therap (facility's computerized record system) to complete documentation from a personal computer after having been placed on suspension, it is recommended that his employment be terminated."</p> <p>Client A's record was reviewed on 8/4/15 at 1:18 PM. Client A's 6/18/15 T (Therap-facility's computer system)-Log progress note indicated "[Client A] has a scratch mark 5cm (centimeters) long and Bruise mark half size of a palm. He is not complaining of any pain, or does not itch...Nurse will be coming to do another observation." Client A's 6/18/15 note did not indicate how client A received the scratch/bruise. Client A's 6/18/15 T-Log also did not indicate where the injuries were found on client A. The facility's T-Log and/or 6/16/15 (sic) reportable incident report indicated the facility did not include, look at and/or investigate the</p>			

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	<p>injuries found on client A on 6/16/15.</p> <p>Interview with staff #5 on 7/30/15 at 6:03 PM indicated when asked if client A required the use of restraints, stated "We are able to talk him down." Staff #5 indicated client A was recently restrained 1 time at the day program.</p> <p>Interview with staff #4 on 7/30/15 at 6:07 PM indicated when asked how often client A had to be restrained, stated "He has never been restrained when I'm here." When asked if clients could be carried as a restraint, staff #4 stated "No." Staff #4 indicated client A would only be restrained if he tried to get into the road.</p> <p>Interview with staff #6 on 7/30/15 at 6:32 PM stated client A "Normally don't require restraints." Staff #6 indicated facility staff would talk to client A and he would calm himself down. Staff #6 indicated client A attended workshop 2 days a week for 2 hours.</p> <p>Interview with the Program Director (PD) on 8/4/15 at 2:44 PM and by email on 8/5/15 at 10:54 AM indicated staff #2 and #3 did not utilize an approved Dungarvin restraint technique on 6/16/15. The PD stated the facility should have utilized a "Two person assist as a last resort" to move client A. The PD stated</p>			

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W 0331 Bldg. 00	<p>"Lifting" was not part of the staffs' training. The PD indicated the staff were trying to prevent client A from injuring his ankle. The PD indicated client A had been off work for 6 months due to a previous ankle injury which required surgery. When asked how client A received the scratch and bruise, the PD stated "Could have been from day program incident." The PD indicated the facility's investigation did not address/investigate client A's injuries found on 6/18/15.</p> <p>This federal tag relates to complaint #IN00176027.</p> <p>9-3-2(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on interview and record review for 1 of 2 sampled clients (A), the facility's nursing services failed to assess and/or document an assessment of the client after the use of an unapproved restraint technique.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and or investigations were reviewed on</p>	W 0331	The Area Director and Program Director have reviewed this deficiency and determined that the staff had completed the body check and documented the injuries and then the Program Director had requested that the nurse come to see the individual to assess the injury. While the primary nurse for the facility was off work on this date, an internal communication request was sent to the nurse who was covering for the primary nurse on the date in	09/10/2015

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	<p>8/4/15 at 12:30 PM. The facility's 6/16/15 (sic) reportable incident report indicated "On 6-17-2015, (sic) [client A] arrived at [name of workshop] planning to attend his [name of program]. Unfortunately, the staff were not supposed to bring [client A] as his behavioral consultants were unable to be here and per his IDT (interdisciplinary team) they will accompany [client A] to [name of program] while he acclimates to his volunteer work at [name of workshop]. [Client A] did not come to Day Program with any of the things he needed; his lunch, his drink for break time, or his glucometer (measures blood sugar level). [Name of workshop] Program Manager, [workshop staff #1] attempted to call [client A's] behavioral consultant when she realized he had come into programming at 8:47 AM. The Dungarvin behavior consultant was frustrated as she felt it had been communicated to staff members that he should not attend today. She said the soonest she could arrive was 30 minutes. Then, [workshop staff #2] informed [workshop staff #1] that he did not have his needed supplies. [Workshop staff #2] called the Dungarvin group home manager, [staff #1], and requested that staff come back and pick up [client A]. [Staff #1] responded that he would send them back. At 9:12 AM, when staff let</p>		<p>question. This nurse never communicated if she had or had not followed up on this request. The Program Director also failed to verify that the nurse visit occurred. The nurse in question is no longer employed by the agency. The primary nurse for the facility is out until 9/14, but the nurse who is covering and the new health services coordinator are being retrained on the importance of assessing and/or documenting an assessment of a client after the use of an unapproved restraint technique. This will be completed by 9/10/15. The primary nurse will also receive this training upon her return.</p>	

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	[client A] know that his staff were on their way back to get him, [client A] screamed and turned over the coffee table in front of him. He got up and ran out of the building and into the parking lot. The [name of workshop staff] working with him, [workshop staff #2], followed him out the door and tried to keep him safe from traffic and from going into the street. [Workshop staff #1] [name of workshop] Program Manager and [administrative staff #2], Director of Family and Community Supports followed [client A] and the staff (workshop staff #2) out the door (sic) were ready to intervene if [client A] went out into the busy street. [Client A] walked around the building and went back inside where he continued to rage in the lobby. He threw items; he swept items off the receptionist's desk, screamed, swore, called names, slapped, hit and kicked staff members. [Name of day program staff] reported that Dungarvin staff backed him up to the counter, held his wrists, forearms, calves and ankles. [Client A] ended up lying on the receptionist's counter. [Client A] continued to hit and kick his staff persons. The Dungarvin staff requested assistance from the [name of day program] staff and [workshop staff #2] went to stabilize [client A] on the counter to prevent him from re injuring (sic) his			

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	<p>ankle or falling from the counter to the floor and provided assistance to the Dungarvin staff. Dungarvin and [name of day program] staff members were holding [client A] and three staff members carried him from the counter further (sic) out into the lobby. [Client A] was fighting, spitting, cursing, and trying to break free. Two staff persons lifted him from each shoulder, and one staff lifted his legs above the ankle. [Workshop staff #1] and [administrative staff #2] were positioned outside to intervene if [client A] went out to the road again. [Name of workshop staff #1], [name of Day Program] Program Manager called [behavior consultant #1] and let her know what was happening, as I was on the phone with her, I turned and saw the staff carrying [client A]. When I saw this was happening, I pointed it out to my director she went inside and told the staff we at [name of workshop] do not carry people who are upset. She requested that the [name of workshop] staff put [client A] down. He (workshop staff #2) lowered [client A] to the floor and backed away. Some staff members stepped in and held his (client A's) arms and legs while he was struggling on the floor. They attempted to calm him using soothing words; he remained very agitated. After some time a Dungarvin staff who had better rapport with [client</p>			
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	<p>A] arrived at [name of workshop]. In just a few minutes, he was able to put [client A] at ease a little bit and [client A] agreed to leave with him. [Client A] was assisted to stand up off the floor and he walked out to Dungarvin's van. [Name of workshop] could not assess [client A] for injury at that time...."</p> <p>The facility's 6/29/15 follow-up report to the 6/16/15 reportable incident report indicated client A was not injured.</p> <p>Client A's record was reviewed on 8/4/15 at 1:18 PM. Client A's 6/18/15 T (Therap-facility's computer system)-Log progress note indicated "[Client A] has a scratch mark 5cm (centimeters) long and Bruise mark half size of a palm. He is not complaining of any pain, or does not itch...Nurse will be coming to do another observation." Client A's 6/18/15 note did not indicate how client A received the scratch/bruise. Client A's 6/18/15 T-Log also did not indicate where the injuries were found on client A. Client A's T-Logs from 6/1/15 to 8/4/15 and the client's computerized record system, indicated the facility's nurse failed to assess and/or document an assessment of client A's injuries.</p> <p>Interview with the Program Director (PD) on 8/4/15 at 2:44 PM and by email on</p>				

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	<p>8/5/15 at 10:54 AM indicated the facility staff were trying to prevent client A from injuring his ankle. The PD indicated client A had been off work for 6 months due to a previous ankle injury which required surgery. When asked how client A received the scratch and bruise, the PD stated "Could have been from day program incident." The PD indicated the facility's nurse was on leave at the time of the incident. The PD indicated the on-call nurse would have assessed client A for any injuries. The PD indicated the nurse's assessment of client A's injuries should have been in the T-logs. The PD did not provide any additional information and/or documentation in regard to an assessment of client A's injuries.</p> <p>This federal tag relates to complaint #IN00176027.</p> <p>9-3-6(a)</p>						