

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G805	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/10/2015
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W 0000  Bldg. 00	<p>This visit was for the investigation of Complaint #IN00179008.</p> <p>Complaint #IN00179008: Substantiated, Federal and State deficiencies related to the allegation are cited at W102, W104, W122, W149, W154, W159, W186, W227, W240, W249 and W263.</p> <p>Dates of Survey: September 2, 3, 4 and 10, 2015.</p> <p>Facility Number: 012633 Provider Number: 15G805 AIMS Number: 201072030</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 9/18/15.</p>	W 0000		
W 0102  Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, record review and interview, the facility failed to meet the</p>	W 0102	<b>CORRECTION:</b>	10/10/2015

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>Condition of Participation: Governing Body for 2 of 2 sampled clients (A and B) and for 2 additional clients (C and D).</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure sufficient safeguards were implemented to prevent recurring elopements for clients A and B and to ensure the clients' health, safety and welfare due to a lack of pedestrian skills.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure all allegations of abuse were thoroughly investigated for clients A, B and D.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure sufficient direct care staff to monitor, supervise and implement the clients' program plans for clients A, B, C and D and to prevent recurring incidents of elopement for clients A and B.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored the clients' active treatment</p>		<p><i>The facility must ensure that specific governing body and management requirements are met. Specifically:</i></p> <p>The QIDP has been retrained regarding the need to bring all elements of the interdisciplinary team together to develop additional supports in response to serious incidents including but not limited to elopement. The QIDP has also been retrained regarding the need to maintain written documentation of all interdisciplinary meetings.</p> <p>The Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than four direct support staff on duty between 6:00 AM and 10:00 PM to prevent elopement and provide for the safety of all clients.</p> <p>The interdisciplinary team will develop prioritized objectives for Client A and Client B to train them toward developing effective pedestrian safety skills. Through observation the team determined that this deficient practice did not affect additional clients.</p>	

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	<p>programs and to ensure the QIDP conducted IDT (Interdisciplinary Team) meetings and documented the meetings and outcomes in the clients' records for clients A, B, C and D.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction over the facility to ensure sufficient safeguards were implemented to prevent recurring elopements for clients A and B and to ensure the clients' health, safety and welfare due to a lack of pedestrian skills.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure all allegations of abuse were thoroughly investigated for clients A, B and D.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure sufficient direct care staff to monitor, supervise and implement the clients' program plans for clients A, B, C and D and to prevent recurring incidents of elopement for clients A and B.</p> <p>The governing body failed to exercise general policy and operating direction</p>		<p>Behavior Support Plans for Client A and Client B will be revised to include assigning one to one supervision duties to specific staff on the day and evening shifts to assure consistent application of enhanced supervision.</p> <p>All staff have been retrained by the Behavioral Clinician regarding the need to position themselves between client A and B and exits as well as to assure that Client A and Client B do not disable or alter the functioning of the exit alarms and to notify a supervisor of any attempts to do so.</p> <p>Malfunctioning alarms will be repaired and/or replaced. Additionally, window alarms will be installed wherever they are not already present in common areas of the home.</p> <p>Staff will perform and document function checks of all alarms no less than once each shift and more frequently as needed. These inspections will include: assuring each alarm is</p>	

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	<p>over the facility to ensure the QIDP integrated, coordinated and monitored the clients' active treatment programs and to ensure the QIDP conducted IDT (Interdisciplinary Team) meetings and documented the meetings and outcomes in the clients' records for clients A, B, C and D. Please see W104.</p> <p>2. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility met the Condition of Participation: Client Protections for clients A, B, C and D. The governing body failed to ensure sufficient safeguards were implemented to prevent recurring elopements of clients A and B and to ensure the clients' health, safety and welfare outside the home due to a lack of pedestrian skills, to ensure sufficient direct care staff were provided to monitor/supervise and implement the clients' program plans for clients A, B, C and D and to ensure all allegations of abuse were investigated thoroughly for clients A, B and D. Please see W122.</p> <p>This federal tag relates to Complaint #IN00179008.</p> <p>9-3-1(a)</p>		<p>operational, assuring the alarms have a uniform alert signal that can be easily distinguished from other sounds in the home and are loud enough to be heard over the ambient level of noise throughout the house.</p> <p>All direct support staff will be retrained and receive ongoing face to face coaching from supervisors regarding the need to provide Client C with consistent, aggressive and continuous active treatment for including but not limited to meal preparation, family style dining, other domestic skills and meaningful leisure activities.</p> <p>Client A's behavior support plan will be modified to include assign specific staff to maintain responsibility for enhanced supervision and prevent elopement. All staff will be trained toward proper implementation of the modified plan.</p> <p>Written informed consent for restrictive programs will be obtained from Client A's guardians. A review of facility</p>	

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			<p>support documents and Human Rights Committee records indicated that this deficient practice did not affect any additional clients.</p> <p><b>PREVENTION:</b></p> <p>The agency will retrain QIDP regarding the need to develop necessary supports and measureable objectives to support clients toward independence. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will incorporate audits of support documents into visits and active treatment observations at the facility twice weekly for the next 30 days and weekly visits for an additional 60 days. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Director of Operations/General Manager will determine the level of ongoing support needed at the facility.</p> <p>The QIDP will submit schedule revisions to the Clinical Supervisor for approval prior to implementation.</p>	

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			<p>The agency will retrain QIDP regarding the need to develop necessary supports and measureable objectives to support clients toward independence.</p> <p>The QIDP has been retrained regarding the need to incorporate all relevant interventions into support plans based on ongoing assessment, review of incident and behavior documentation and interdisciplinary input.</p> <p>When guardians and healthcare representatives are unable to attend team meetings face to face, consent forms will be sent via postal mail for review and signature, along with a stamped envelope addressed to the facility. If consents are not returned to the facility in a timely manner via standard postal mail, the QIDP will send the forms to the appropriate legal representative via registered mail to assure the documents have been delivered and received.</p>	

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			<p>The QIDP has been retrained regarding the need to incorporate all relevant interventions into support plans based on ongoing assessment, review of incident and behavior documentation and interdisciplinary input.</p> <p>The QIDP will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to meal preparation, family style dining, other domestic skills and meaningful leisure activities and implementation of behavior supports. Members of the Operations Team and the QIDP will conduct observations during active treatment sessions no less than twice weekly for the next 30 days, and no less than weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM</p>	

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			<p>and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and</p>	

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			<p>Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility.</p> <p>Administrative oversight at the facility will include but not be limited to:</p> <ol style="list-style-type: none"> <li>1. Assuring that interdisciplinary team meetings occur and are documented as needed and in response to significant incidents.</li> <li>2. Assuring appropriate supports are included in each client's support plan.</li> <li>3. Direct face to face assessment of clients to compare observed behaviors and needs with current support documents and making recommendations for revisions as appropriate.</li> <li>4. Assuring adequate direct support staff are on duty to meet the needs of all clients.</li> </ol>	

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W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 2 of 2 sampled clients (A and B) and 2 additional clients (C and D), the governing body failed to exercise general policy and operating direction over the facility to ensure sufficient safeguards were implemented to prevent recurring elopements and to ensure the clients' health, safety and welfare due to a lack of pedestrian skills for clients A and B.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure all allegations</p>	W 0104	<p>5. Assuring continuous active treatment occurs with all clients.</p> <p>6. Assuring prior written informed consent has been obtained for all restrictive programs.</p> <p><b>RESPONSIBLE PARTIES:</b>  QIDP, Behavioral Clinician, Direct Support Staff, Operations Team, Director of Operations/General Manager</p> <p><b>CORRECTION:</b>  <i>The Governing body must exercise general policy, budget and operating direction over the facility. Specifically:</i></p> <p>The QIDP has been retrained regarding the need to bring all elements of the interdisciplinary team together to develop additional supports in response to serious incidents including but not limited to elopement. The QIDP has also been retrained regarding</p>	10/10/2015

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	<p>of abuse were thoroughly investigated for clients A, B and D.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure sufficient direct care staff to monitor, supervise and implement the clients' program plans for clients A, B, C and D and to prevent recurring incidents of elopement for clients A and B.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored the clients' active treatment programs and to ensure the QIDP conducted IDT (Interdisciplinary Team) meetings and documented the meetings and outcomes in the clients' records for clients A, B, C and D.</p> <p>Findings include:</p> <p>1. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure sufficient safeguards were implemented to prevent recurring elopements and to ensure the clients' health, safety and welfare outside the home due to a lack of pedestrian skills for clients A and B. The</p>		<p>the need to maintain written documentation of all interdisciplinary meetings.</p> <p>The Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than four direct support staff on duty between 6:00 AM and 10:00 PM to prevent elopement and provide for the safety of all clients.</p> <p>The interdisciplinary team will develop prioritized objectives for Client A and Client B to train them toward developing effective pedestrian safety skills. Through observation the team determined that this deficient practice did not affect additional clients.</p> <p>Behavior Support Plans for Client A and Client B will be revised to include assigning one to one supervision duties to specific staff on the day and evening shifts to assure consistent application of enhanced supervision.</p> <p>All staff have been retrained by the Behavioral Clinician regarding</p>	

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	<p>facility's governing body failed to exercise general policy and operating direction over the facility to ensure sufficient direct care staff were provided to monitor/supervise and implement the clients' program plans for clients A, B, C and D and to prevent recurring incidents of elopements for clients A and B. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure all allegations of abuse were thoroughly investigated for clients A, B and D. Please see W149.</p> <p>2. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure all allegations of abuse were thoroughly investigated for clients A, B and D. Please see W154.</p> <p>3. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the QIDP integrated, coordinated and monitored the clients' active treatment programs and to ensure the QIDP conducted IDT (Interdisciplinary Team) meetings and documented the meetings and outcomes in the clients' records for clients A, B, C and D. Please see W159.</p> <p>4. The facility's governing body failed to</p>		<p>the need to position themselves between client A and B and exits as well as to assure that Client A and Client B do not disable or alter the functioning of the exit alarms and to notify a supervisor of any attempts to do so.</p> <p>Malfunctioning alarms will be repaired and/or replaced. Additionally, window alarms will be installed wherever they are not already present in common areas of the home.</p> <p>Staff will perform and document function checks of all alarms no less than once each shift and more frequently as needed. These inspections will include: assuring each alarm is operational, assuring the alarms have a uniform alert signal that can be easily distinguished from other sounds in the home and are loud enough to be heard over the ambient level of noise throughout the house.</p> <p>All direct support staff will be retrained and receive ongoing face to face coaching from supervisors regarding the need to provide Client C with consistent,</p>				

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	<p>exercise general policy and operating direction over the facility to ensure sufficient direct care staff were provided to monitor, supervise and implement the clients' program plans for clients A, B, C and D and to prevent recurring incidents of elopement for clients A and B. Please see W186.</p> <p>This federal tag relates to Complaint #IN00179008.</p> <p>9-3-1(a)</p>		<p>aggressive and continuous active treatment including but not limited to meal preparation, family style dining, other domestic skills and meaningful leisure activities.</p> <p>Client A's behavior support plan will be modified to include assign specific staff to maintain responsibility for enhanced supervision and prevent elopement. All staff will be trained toward proper implementation of the modified plan.</p> <p>Written informed consent for restrictive programs will be obtained from Client A's guardians. A review of facility support documents and Human Rights Committee records indicated that this deficient practice did not affect any additional clients.</p> <p><b>PREVENTION:</b></p> <p>The agency will retrain QIDP regarding the need to develop necessary supports and measureable objectives to support clients toward</p>	

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			<p>independence. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will incorporate audits of support documents into visits and active treatment observations at the facility twice weekly for the next 30 days and weekly visits for an additional 60 days. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Director of Operations/General Manager will determine the level of ongoing support needed at the facility.</p> <p>The QIDP will submit schedule revisions to the Clinical Supervisor for approval prior to implementation.</p> <p>The agency will retrain QIDP regarding the need to develop necessary supports and measureable objectives to support clients toward independence.</p> <p>The QIDP has been retrained regarding the need to incorporate all relevant interventions into</p>	

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			<p>support plans based on ongoing assessment, review of incident and behavior documentation and interdisciplinary input.</p> <p>When guardians and healthcare representatives are unable to attend team meetings face to face, consent forms will be sent via postal mail for review and signature, along with a stamped envelope addressed to the facility. If consents are not returned to the facility in a timely manner via standard postal mail, the QIDP will send the forms to the appropriate legal representative via registered mail to assure the documents have been delivered and received.</p> <p>The QIDP has been retrained regarding the need to incorporate all relevant interventions into support plans based on ongoing assessment, review of incident and behavior documentation and interdisciplinary input.</p> <p>The QIDP will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and</p>	

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			<p>monitor skills training including but not limited to meal preparation, family style dining, other domestic skills and meaningful leisure activities and implementation of behavior supports. Members of the Operations Team and the QIDP will conduct observations during active treatment sessions no less than twice weekly for the next 30 days, and no less than weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through</p>	

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			<p>the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility.</p> <p>Administrative oversight at the facility will include but not be</p>	

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			<p>limited to:</p> <ol style="list-style-type: none"> <li>1. Assuring that interdisciplinary team meetings occur and are documented as needed and in response to significant incidents.</li> <li>2. Assuring appropriate supports are included in each client's support plan.</li> <li>3. Direct face to face assessment of clients to compare observed behaviors and needs with current support documents and making recommendations for revisions as appropriate.</li> <li>4. Assuring adequate direct support staff are on duty to meet the needs of all clients.</li> <li>5. Assuring continuous active treatment occurs with all clients.</li> <li>6. Assuring prior written informed consent has been obtained for all restrictive programs.</li> </ol> <p><b>RESPONSIBLE PARTIES:</b></p> <p>QIDP, Behavioral Clinician, Direct Support Staff, Operations Team, Director of Operations/General</p>	

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W 0122 Bldg. 00	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 2 of 4 sampled clients, (A and B) and 2 additional clients (C and D).</p> <p>The facility failed to implement its policy and procedures to ensure sufficient safeguards were implemented to prevent recurring elopements of clients A and B and to ensure the clients' health, safety and welfare outside the home due to a lack of pedestrian skills.</p> <p>The facility failed to provide sufficient direct care staff to monitor/supervise and implement the clients' program plans for clients A, B, C and D and to prevent recurring elopements for clients A and B.</p> <p>The facility failed to implement its policy and procedures to ensure all allegations of abuse were investigated thoroughly for clients A, B and D.</p> <p>Findings include:</p> <p>1. The facility failed to implement its</p>	W 0122	<p>Manager</p> <p><b>CORRECTION:</b> <i>The facility must ensure that specific client protections requirements are met.</i> Specifically, the governing body has facilitated the following:</p> <p>The interdisciplinary team will develop prioritized objectives for Client A and Client B to train them toward developing effective pedestrian safety skills.</p> <p>Behavior Support Plans for Client A and Client B will be revised to include assigning one to one supervision duties to specific staff on the day and evening shifts to assure consistent application of enhanced supervision.</p> <p>All staff have been retrained by the Behavioral Clinician regarding the need to position themselves between client A and B and exits as well as to assure that Client A and Client B do not disable or alter the functioning of the exit alarms and to notify a supervisor of any attempts to do so.</p> <p>Malfunctioning alarms will be</p>	10/10/2015

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	<p>policy and procedures to ensure sufficient safeguards were implemented to prevent recurring elopements, to ensure the clients' health, safety and welfare outside the home due to a lack of pedestrian skills, to ensure sufficient direct care staff to monitor/supervise and implement the clients' program plans and to ensure all allegations of abuse were thoroughly investigated for clients A, B, C and D. Please see W149.</p> <p>2. The facility failed to implement its policy and procedures to ensure all allegations of abuse were investigated and/or thoroughly investigated for clients A, B and D. Please see W154.</p> <p>3. The facility failed to implement its policy and procedures to ensure sufficient direct care staff to monitor/supervise and implement the clients' program plans and to prevent recurring elopements for clients A, B, C and D. Please see W186.</p> <p>This federal tag relates to Complaint #IN00179008.</p> <p>9-3-2(a)</p>		<p>repaired and/or replaced. Additionally, window alarms will be installed wherever they are not already present in common areas of the home.</p> <p>Staff will perform and document function checks of all alarms no less than once each shift and more frequently as needed. These inspections will include: assuring each alarm is operational, assuring the alarms have a uniform alert signal that can be easily distinguished from other sounds in the home and are loud enough to be heard over the ambient level of noise throughout the house.</p> <p>the Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than four direct support staff on duty between 6:00 AM and 10:00 PM to prevent elopement and provide for the safety of all clients.</p> <p>The Operations Team, including the Program Manager and Clinical Supervisor, will directly oversee all investigations. The QIDP will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews. The training will also stress the importance of assuring the investigative process determines if discovered injuries</p>	

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			<p>occurred as a result of staff negligence. The Clinical Supervisor and Program Manager will assure that conclusions are developed that match the collected evidence. When any evidence of staff negligence or mistreatment is uncovered or alleged the Operations Team will take control of all aspects of the investigation process. Specifically for Client A, the individual has a long history of making false and unsubstantiated allegations of mistreatment which is addressed in his Behavior Support Plan. Staff and the QIDP will receive retraining toward proper implementation of the plan's reactive strategies to assure that all allegations of abuse, neglect, mistreatment or exploitation are investigated thoroughly.</p> <p><b>PREVENTION:</b> The agency will retrain QIDP regarding the need to develop necessary supports and measureable objectives to support clients toward independence. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will incorporate audits of support documents into visits and active treatment observations at the facility twice weekly for the next 30 days and weekly visits for an</p>	

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			<p>additional 60 days. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Director of Operations/General Manager will determine the level of ongoing support needed at the facility.</p> <p>the Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than four direct support staff on duty between 6:00 AM and 10:00 PM to prevent elopement and provide for the safety of all clients.</p> <p>The QIDP has been retrained regarding the need to incorporate all relevant interventions into support plans based on ongoing assessment, review of incident and behavior documentation and interdisciplinary input. Members of the Operations Team and the QIDP will conduct observations during active treatment sessions no less than twice weekly for the next 30 days, and no less than weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p>	

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			<p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making</p>	

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			<p>recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility.</p> <p>Administrative oversight at the facility will include but not be limited to:</p> <ol style="list-style-type: none"> <li>1. Assuring appropriate supports are included in each client's support plan.</li> <li>2. Direct face to face assessment of clients to compare observed behaviors and needs with current support documents and making recommendations for revisions as appropriate.</li> <li>3. Assuring adequate direct support staff are on duty to meet the needs of all clients.</li> </ol> <p>A tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and the Executive Director. The Clinical Supervisor (Administrative level management) will meet with his/her facility management teams weekly to review the progress made on all investigations that are open for</p>	

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			<p>their homes. Residential Managers will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Clinical Supervisor will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. The Program Manager will also conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations. Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members.</p> <p><b>RESPONSIBLE PARTIES:</b> QIDP, Behavioral Clinician, Direct Support Staff, Operations Team, Director of Operations/General Manager</p>	

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W 0149  Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 2 of 4 sampled clients (A and B), the facility failed to implement its policy and procedures to ensure sufficient safeguards were implemented to prevent recurring elopements and to ensure the clients' health, safety and welfare outside the home due to a lack of pedestrian skills for clients A and B.</p> <p>The facility failed to implement its policy and procedures to ensure sufficient direct care staff to monitor/supervise and implement the clients' program plans for clients A, B, C and D and to prevent recurring incidents of elopements for clients A and B.</p> <p>The facility failed to implement its policy and procedures to ensure all allegations of abuse were thoroughly investigated for clients A, B and D.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 9/2/15 between 3:30 PM and 5 PM. __ There were three direct care staff with four male clients (clients A, B, C and D).</p>	W 0149	<p><b>CORRECTION:</b></p> <p><i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically,</i></p> <p>The interdisciplinary team will develop prioritized objectives for Client A and Client B to train them toward developing effective pedestrian safety skills.</p> <p>Behavior Support Plans for Client A and Client B will be revised to include assigning one to one supervision duties to specific staff on the day and evening shifts to assure consistent application of enhanced supervision.</p> <p>All staff have been retrained by the Behavioral Clinician regarding the need to position themselves between client A and B and exits as well as to assure that Client A and Client B do not disable or alter the functioning of the exit</p>	10/10/2015

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	<p>__The group home was a single level home with four bedrooms, two and half baths, two living rooms/entertainment rooms, a medication room, a kitchen, a laundry room, a small office and an attached garage.</p> <p>__The home was located on a side road and was 0.2 miles (352 yards) from a major busy highway.</p> <p>__The local police station was located on the same busy highway a few yards from the end of the road the group home was located on and was visible from the group home.</p> <p>__There were egress doors in the dining room (the front door), the small living room (the side door), the large living room (the back door) and the garage door. All egress doors had alarms on them.</p> <p>__The back door opened up to a small area that was surrounded by a privacy fence with a gate allowing access to the large back yard.</p> <p>__The alarm on the back door by the QIDP's office was broken and non functioning.</p> <p>__The alarms on each egress door had different sounds that were not ear piercing but sounded like door bells and at times were difficult to hear above the noise in the home.</p> <p>__Client A had two large windows in his room. No alarms were observed on the</p>		<p>alarms and to notify a supervisor of any attempts to do so.</p> <p>Malfunctioning alarms will be repaired and/or replaced. Additionally, window alarms will be installed wherever they are not already present in common areas of the home.</p> <p>Staff will perform and document function checks of all alarms no less than once each shift and more frequently as needed. These inspections will include: assuring each alarm is operational, assuring the alarms have a uniform alert signal that can be easily distinguished from other sounds in the home and are loud enough to be heard over the ambient level of noise throughout the house.</p> <p>the Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than four direct support staff on duty between 6:00 AM and 10:00 PM to prevent elopement and provide for the safety of all clients.</p>	

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	<p>windows.</p> <p>__ Client B had two windows in his room. One window had a functioning alarm and the other window had no alarm.</p> <p>__ There were no functioning alarms on the dining room and living room windows.</p> <p>__ Client A was a young male that was loud, was in constant motion, was fast on his feet and was invasive of his peers' and the staffs' personal space.</p> <p>__ Client B was a quiet older male that was short in stature, had a slight forward lean and ambulated at a moderate pace.</p> <p>At 3:30 PM:</p> <p>__ Client A escorted this surveyor around his home starting with his bedroom.</p> <p>__ Client A had two large windows in his bedroom.</p> <p>__ Client A walked to the garage and pointed out his desk and furniture that used to be in his room but was now broken.</p> <p>__ Client A pointed out alarms on the doors and the windows and indicated he could turn the alarms off, change the sounds and/or take them down.</p> <p>__ Client A walked to the main bathroom and pointed out how the toilet was not working properly. Client A put both arms around the toilet bowl and began shifting the toilet up and sideways from the base of the floor.</p>		<p>The Operations Team, including the Program Manager and Clinical Supervisor, will directly oversee all investigations. The QIDP will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews. The training will also stress the importance of assuring the investigative process determines if discovered injuries occurred as a result of staff negligence. The Clinical Supervisor and Program Manager will assure that conclusions are developed that match the collected evidence. When any evidence of staff negligence or mistreatment is uncovered or alleged the Operations Team will take control of all aspects of the investigation process. Specifically for Client A, the individual has a long history of making false and unsubstantiated allegations of mistreatment which is addressed in his Behavior Support Plan. Staff and the QIDP will receive retraining toward proper implementation of the plan's reactive strategies to assure that all allegations of abuse, neglect, mistreatment or exploitation are investigated thoroughly.</p> <p><b>PREVENTION:</b></p>	

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	<p>__ Staff #5 indicated client A had broken the toilet and the staff were waiting for the repairman to fix it.</p> <p>__ Staff #5 stated the half bath was kept locked "in case he (client A) would break the other bathroom" and indicated the staff carried the key to the half bath.</p> <p>__ Staff #5 stated the home had another full bath but client A had "messed with the pipes under the sink and the pipes were leaking" and the pipes were in need of repair.</p> <p>__ Client A's behaviors began to escalate. Client A got louder and began cursing at the staff, telling the staff to "shut up" while darting in and around the staff and other clients that were nearby.</p> <p>__ The PC (Program Coordinator) that was sitting at the dining room table at the time stated to client A, "Now you know that's not nice. Why don't you go outside for a little while?"</p> <p>At 4:05 PM:</p> <p>__ Client A lunged toward the QIDP. Due to client A's escalating behaviors, staff #5 suggested to client A that he go outside with staff #5 to play basketball or to sweep the sidewalk. Staff #5 and client A went outside.</p> <p>__ Staff #5 and client A went outside to sweep the sidewalk.</p> <p>__ Staff #5 remained nearby client A throughout the observation.</p>		<p>The agency will retrain QIDP regarding the need to develop necessary supports and measureable objectives to support clients toward independence. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will incorporate audits of support documents into visits and active treatment observations at the facility twice weekly for the next 30 days and weekly visits for an additional 60 days. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Director of Operations/General Manager will determine the level of ongoing support needed at the facility.</p> <p>The Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than four direct support staff on duty between 6:00 AM and 10:00 PM to prevent elopement and provide for the safety of all clients.</p> <p>The QIDP has been retrained regarding the need to incorporate all relevant interventions into</p>	

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	<p>__ Staff #5 was not within arms reach of client #5 throughout the observation.</p> <p>__ During this observation period client A frequently would run from one part of the home to another while the staff supervising client A would be several feet behind client A and within a few feet of rounding a corner. For a few seconds client A would be out of eyesight for the staff, giving client A the opportunity to exit the home.</p> <p>Observations were conducted at the group home on 9/3/15 between 4:30 PM and 5 PM.</p> <p>__ At 4:30 PM client A was in his bedroom and staff #8 stood outside of client A's bedroom door.</p> <p>__ At 4:40 PM client A ran out of his bedroom and into the dining room.</p> <p>__ Staff #8 walked slowly behind him and did not have client A in line of sight at all times.</p> <p>__ Client A began running in and around the dining room table, going in and out of the kitchen, in and around the other staff while making fun of staff, bumping into the staff and laughing about it.</p> <p>During this observation period:</p> <p>__ Client A was near the egress door in the dining room while two of the three staff were in the kitchen.</p> <p>__ Staff #8 was standing near the kitchen</p>		<p>support plans based on ongoing assessment, review of incident and behavior documentation and interdisciplinary input. Members of the Operations Team and the QIDP will conduct observations during active treatment sessions no less than twice weekly for the next 30 days, and no less than weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure</p>	

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	<p>on the opposite side of the table several feet away from client A.</p> <p>__Staff #8 would not be able to prevent client A from running out the front door at that time if client A had decided to leave.</p> <p>During both observation periods the staff did not stay within arms reach of client A. The staff was not observed to position themselves between the egress doors and client A or client B.</p> <p>The facility reportable and investigative records were reviewed on 9/2/15 at 1 PM.</p> <p>The 10/7/14 Bureau of Developmental Disabilities Services (BDDS) report indicated on 10/6/14 at 10:15 PM "[Client A] was sitting at the dining room table when he got up and ran out the front door. Staff followed and [client A] stopped at highway [name of highway]. Staff caught up and attempted to verbally redirect [client A] back to the house. [Client A] refused and for his (client A's) safety staff used YSIS (You're Safe I'm Safe - a physical hold used to control behavior) standing to his (client A's) side assiting (sic) him back to the house. Once back, [client A] went to bed without further incident."</p> <p>__The report indicated "Plan to Resolve (Immediate and Long Term). [Client A]</p>		<p>skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility.</p> <p>Administrative oversight at the facility will include but not be limited to:</p>	

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	<p>has a history of running for no reason. [Client A] did not appear to be upset or angry when he ran. Due to his continued running he has an appointment with his psychiatrist (sic) moved up to this Thursday (10/9/14)."</p> <p>The 3/30/15 Incident/Accident Report (IAR) indicated at 6:33 PM "[Staff #3 and staff #1] were out front (of the house) with [client D]. [Client A] saw us, came outside with [staff #6]. We stood in doorway, [client A] took off running towards the stream. [Staff #1] went to get him [client A], his leg hit a stick and caused a scrape.... Staff stated, [client A] said 'PoPo (the police)' and made his hand like a gun and went towards the tree. Therefore this not (sic) an elopement attempt but [client A] playing around. The team will continue to follow his support plan and encourage [client A] to use the back yard instead of the front to avoid running towards the road."</p> <p>The 4/26/15 BDDS report indicated on 4/25/15 at 8 PM "[Client A] was sitting at the dining room table and started to cry and say he wanted mom. [Client A] then got up and ran out the door. Staff verbally redirected to come back inside and [client A] became physically aggressive swinging an object he had at staff. Staff was able to block. [Client A] was placed</p>		<ol style="list-style-type: none"> <li>1. Assuring appropriate supports are included in each client's support plan.</li> <li>2. Direct face to face assessment of clients to compare observed behaviors and needs with current support documents and making recommendations for revisions as appropriate.</li> <li>3. Assuring adequate direct support staff are on duty to meet the needs of all clients.</li> </ol> <p>A tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and the Executive Director. The Clinical Supervisor (Administrative level management) will meet with his/her facility management teams weekly to review the progress made on all investigations that are open for their homes. Residential Managers will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations</p>	

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	<p>into a two person YSIS hold for safety where one staff was on each side (of client A). [Client A] spit at staff and attempted to bite.... [Client A] calmed after a couple of minutes and then the hold was released. [Client A] went inside without further incident."</p> <p>__The report indicated "Plan to Resolve (Immediate and Long Term). No one was injured during the incident. YSIS is approved in [client A's] support plan and no injuries or marks where (sic) noted from the hold. [Client A] has a history of running when upset. The team will continue to follow [client A's] support plan to help prevent and reduce further incidents."</p> <p>__The 4/25/15 IAR indicated it was 8 PM and client A was in his pajamas when he went outside and the temperature outside was 34 degrees Fahrenheit.</p> <p>The 5/5/15 BDDS report indicated on 5/4/15 at 4 PM "[Client A] came out of his bedroom pulling his pants and underwear down to his ankles. [Client A] started laughing and grabbed his private area and started running through the house asking everyone to look at his private area while attempting to run. Staff redirected [client A] that he was being inappropriate and to please pull his pants up. Before staff could reach [client A], he</p>		<p>with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Clinical Supervisor will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. The Program Manager will also conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations. Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members.</p> <p><b>RESPONSIBLE PARTIES:</b></p> <p>QIDP, Behavioral Clinician, Direct Support Staff, Operations Team, Director of Operations/General Manager</p>	

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	<p>tripped over his pants and fell into his door frame. [Client A's] inner thigh had connected with the door frame and [client A] laid on the floor laughing. When the staff called the QIDP to inform him [client A] grabbed the phone from staff and ran out the front door. Staff followed and when they caught up to him he stopped running and returned to the house with staff."</p> <p>__The report indicated "Plan to Resolve (Immediate and Long Term). [Client A] had a 3 inch red area on his inner thigh from where he fell into the door frame. Staff is monitoring and no first aid was necessary. The team will continue to follow [client A's] support plan to help prevent and reduce further occurrences."</p> <p>__The 5/7/15 Follow Up BDDS report indicated "[Client A] was not out of staff's line of sight. [Client A's] male peers did see [client A] exposing himself they where (sic) in the living room. [Client A's] pants where (sic) pulled up prior to running out the door. Leaving assigned area and sexual inappropriateness (sic) are addressed in [client A's] support plan. The team will continue to follow [client A's] support plan to help prevent and reduce further incidents."</p> <p>The 5/7/15 BDDS report indicated on 5/7/15 at 7:35 AM "[Client A] was in his</p>			

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	<p>bedroom on the phone talking and was upset asking to move out and for his mom. Staff heard a school bus honking and staff went outside and the bus driver thought one of the individuals was walking down the road. Staff saw [client A] walking towards highway [name of highway] and caught up with [client A] at the [name of police] station which is less than 100 yards from site (sic). [Client A] returned to the house without incident."</p> <p>__The BDDS report indicated "Plan to Resolve (Immediate and Long Term). [Client A] was out of sight for less than two minutes. [Client A] went out the back door to the front of the house and down the road. Once staff was aware [client A] was on the road he was not out of staff's sight. No injury occurred during the incident. One staff was using the restroom and one staff was doing medication check and the third staff was preparing [client A's] medical chart for his doctor's appointment this morning. Leaving assigned area is a behavior that is tracked in [client A's] behavior plan."</p> <p>__The Elopement/Missing Person Investigation Summary dated 5/7/15 indicated: Client A "must have slipped out the back door by his room (bedroom)." Client A was able to turn off the door alarm by himself. Client A was discovered walking on the</p>			

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	<p>street in front of the group home and was headed toward a busy highway.</p> <p>The staff realized the client was gone when they heard the bus driver honking the horn.</p> <p>Client A knew how to disarm the door alarms.</p> <p>"Recommendations to discuss at IDT (Interdisciplinary Team) meeting: Different door alarms."</p> <p>__The 5/7/15 Confidential Witness Statement Form (CWSF) from staff #3 indicated client A had asked to call the Behavior Clinician (BC) and had taken the phone to his bedroom. Staff #3 indicated he began preparing client A's record for an appointment. "A couple min (minutes) pas (sic) I (staff #3) heard bus driver out front honking. [Staff #7] and I (staff #3) went outside. Driver (bus driver) said, 'I think one of your guys got away.' I looked towards [name of highway] and observe (sic) [client A] walking toward police station and I took off on foot after him."</p> <p>__The 5/7/15 CWSF from staff #7 indicated staff #3 chased after client A on foot and staff #7 got the keys and followed in the facility van.</p> <p>The 5/18/15 IAR indicated at 5:45 PM "[Client A] got mad because he said he wants to run outside. Started hitting</p>			

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	<p>elbow and hand on bedroom window repeatedly yelling, 'I want to run. I want to die'."</p> <p>The 5/19/15 IAR indicated at 3:13 PM "[Client A] followed the staff outside while staff went to get a sweater out of car. As we (staff and client A) were coming inside, he (client A) acted like the 'PoPo' and took off towards the creek. Staff ran after him, tried to stop him from running through the creek. He (client A) went knees first, no injury noted, he came inside and is ok, left knee is a little red."</p> <p>The 5/26/15 BDDS report indicated on 5/26/15 at 1:05 PM "[Client B] moved in at noon and was upset about moving. [Client B] walked out the front door a total of five times attempting to walk home. [Client B] was never out of staff site (sic). The fourth time he walked out [client B] tripped on the terrain of the side of the road and landed on his right knee. [Client B's] right knee was skinned one inch in diameter and bleed slightly. All times that [client B] walked out he came back with verbal redirection. [Client B] was physically aggressive on the time he fell attempting to punch staff, but no one was injured." The BDDS report indicated "Plan to Resolve (Immediate and Long Term). The nurse was notified of the fall and</p>			

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	<p>injury. The injured area was cleaned. The team will monitor the area until gone. [Client B] has not made any more attempts to walk out the door."</p> <p>The 5/27/15 BDDS report indicated on 5/27/15 at 11 AM "[Client B] ran out the front door towards the road not leaving staff's line of sight. Staff caught up to [client B] to verbally redirect him to the house and he became physically aggressive toward staff attempting to hit and kick. [Client B] was verbally aggressive saying 'I will kill you; I will slit your throat.' Staff was able to block and gave [client B] time to calm. [Client B] returned to the house and started throwing chairs at staff and making threats. Staff applied a two person YSIS hold for safety where one staff stood on each side of [client B] with one hand on his wrist and the other arm around his waist. The hold was released after two minutes the staff talked to [client B] and was calm without further incident."</p> <p>__The BDDS report indicated "Plan to Resolve (Immediate and Long Term). No one was injured during the behavior. [Client B] was not injured from the YSIS hold. YSIS is approved in [client B's] plan. [Client B] is upset about moving and the team will continue to offer choices and talking to [client B] to help reduce further incidents."</p>			

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	<p>The 6/2/15 BDDS report indicated on 6/2/15 at 9 AM "[Client B] was resting in his room. Staff member went to move their car and noticed [client B] walking on the road and went to catch up to him. Staff alerted coworkers and another staff went to assist. [Client B] returned with staff and attempted to walk out the door. Staff blocked and [client B] became verbally aggressive threatening (sic) to stab and cut staff. [Client B] became physically aggressive attempting to hit and kick staff. Staff where (sic) able to block. This lasted on and off for about an hour. Staff offered choices [(music, talking)] to help [client B] calm during the incident. [Client B] finally calmed and sat with staff and watched television."</p> <p>__The BDDS report indicated: "Plan to Resolve (Immediate and Long Term). No one was injured during the incident. [Client B] was out of staff site (sic) for two minutes and had left through the back door and out the gate in back yard. One staff was in the other living room with a housemate, one staff was in the medication room faxing and the other staff was at the dining room table getting a housemate their daily finances. [Client B] continues to state that he wants to move to [name of town] [(where he is from)]. Leaving assigned area is</p>			
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	<p>addressed in [client B's] support plan and is being tracked. The team will continue to follow [client B's] support plan to help prevent and reduce further incidents."</p> <p>The 6/16/15 IAR indicated at 6:10 AM client A "took off out the front door" toward the driveway while the 3rd shift staff was leaving. The staff tried to stop him but was unable to and client A "ran into a staff's truck." The staff caught him as he was falling and client A got up and chased the staff as they were leaving. Client A calmed down and returned inside the home."</p> <p>The 6/30/15 BDDS report indicated on 6/29/15 at 3:30 PM "[Client B] walked out the back door and staff followed to keep him in sight. Staff sat down next to [client B] and [client B] grabbed at staff's clothing. Staff blocked and [client B] continued to grab at staff. Another staff member came out to assist and verbal (sic) redirected [client B] who then became physically aggressive towards that staff member. Staff member placed [client B] into a one person YSIS hold [(one person standing restraint)] for less than a minute by standing next to [client B] and placed one hand on his wrist to prevent him from punching. [Client B] calmed and hold was released. [Client B] apologized and had no further incidents."</p>			

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	<p>The BDDS report indicated "Plan to Resolve (Immediate and Long Term). No one was injured during the incident and [client B] was not injured from the hold. [Client B] has a history of sudden physical aggression that is being tracked and YSIS is in his support plan. The team will continue to follow [client B's] plan to reduce and prevent further incidents."</p> <p>The 7/6/15 IAR indicated at 7 PM client A ran out the front door to the back yard wooded area in sight of staff. Client A was directed back into the house and he sat down on the couch. Client A then tried to run out the back door. The staff talked to client A and calmed him down.</p> <p>The 7/7/15 IAR indicated at 5 PM client A heard thunder and ran out of the house into the front yard and stood in the rain. The report indicated the staff directed client A to come back into the house and client A ran into the house, slipped and fell and obtained red marks on his right elbow and left knee.</p> <p>The 7/15/15 IAR indicated at 6:08 PM client A "eloped out the front door as staff was leaving." The report indicated client A headed to the back of the house around the garage and staff followed him trying to redirect him. Client A slipped on the wet grass and fell. Client A</p>			

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	<p>returned to the inside of the house.</p> <p>The 7/15/15 IAR indicated at 7:20 PM client A was yelling he wanted his mother and that he wanted to die. Client A started cursing at his house mates and the staff saying "Die, die, I want to die." Client A ran out of the front door and down the street toward a major highway. The staff ran after client A and grabbed client A by the shirt to stop him from running into oncoming traffic. The IAR indicated client A was not out of sight of staff and was directed back to the group home.</p> <p>The 7/17/15 BDDS report indicated on 7/16/15 at 6:23 PM "[Client B] was in the kitchen and a staff came into work. [Client B] went out the front door and slammed it. [Client B] started to run, yelling at staff to go home. Staff caught up to him and attempted to verbally redirect him to the house. [Client B] fell in the ditch beside the road and scraped his right cheek and a scrape on right knee. [Client B] went back to the house with staff with no further incidents." __The BDDS report indicated "Plan to Resolve (Immediate and Long Term). The scrape on cheek is three in (inches) not bleeding and red in color. The scrape on right knee is 1 cm red in color and not bleeding. Nurse was notified and areas</p>			

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	<p>where (sic) cleansed with water and triple antibiotic ointment was applied. [Client B] was in staff's line of sight to whole incident. [Client B] has a history of leaving assigned area and is monitored in his support plan. The team will continue to follow [client B's] support plan to help prevent and reduce further incidents."</p> <p>The 7/24/15 BDDS report indicated on 7/24/15 at 4:30 AM (sic - PM) "[Client A] ran around the car and kept running towards highway [name of highway]. Staff was running after and two cars had turned off of [name of highway] onto [name of road of group home] road. [Client A] was running down the road on the same side as the car and did not stop even though he could see the cars coming at him. The cars stopped and staff was able to catch up to [client A] before he reached highway [name of highway] by grabbing a hold of his hoodie (a sweatshirt). [Client A] stopped and staff immediately let go and walked back to the house with [client A]. Once back in the house [client A] became verbally aggressive toward staff and physically aggressive, attempting to punch staff. Staff blocked and [client A] started to fall backwards after swinging. Staff reached out to help prevent [client A] from falling by taking ahold (sic) of his shirt which ripped, but [client A] did not fall. Staff</p>			

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	<p>immediately let go and [client A] grabbed a chair throwing it at staff that blocked. Staff continued to offer coping mechanisms and [client A] went to his room where he calmed with no further incidents."</p> <p>__The report indicated "Plan to Resolve (Immediate and Long Term). No one was injured during the incident. [Client A] has a history of running when upset. [Client A] was within line of sight of staff. One staff was gone in the van with another client. One staff was on the front porch with two clients. The third staff was sitting at the dining room table with [client A]. Leaving assigned area is in support plan and tracked. The team will continue to follow [client A's] support plan to help reduce and prevent further incidents."</p> <p>The 8/2/15 BDDS report indicated on 8/2/15 at 5:35 PM "[Client B] ran out the back door. He (client B) came back inside and appeared to have calmed down. He ran a second time towards the back gate when he fell on the step, landing on his right knee and right hand. He calmed down and came back inside the house."</p> <p>__The BDDS report indicated "Plan to Resolve (Immediate and Long Term). [Client B] received a red scrape on his right knee with a 3-4 cm (centimeter)</p>			

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	<p>light abrasion. Staff will apply first aid as needed and report any changes to the nurse."</p> <p>The 8/13/15 BDDS report indicated on 8/13/15 at 10:30 AM "[Client B] returned from a doctor's appointment and told staff that he was going to run. Staff followed [client B] out the front door and where (sic) able to verbally redirect him back to the house. Once back in the house [client B] became physically aggressive and attempted to punch staff. [Client B] also attempted to kick and throw objects at staff. Staff was able to block. [Client B] apologized to staff and said that he was going to his room to calm down. Near his room he grabbed a card table and flipped it and said he was going to run. [Client B] then went out the back door and slammed it shut holding it closed. Staff went out the other door and [client B] swung at staff missing. [Client B] pushed staff attempting to go out the back gate. Staff attempted to redirect and [client B] grabbed the staff throwing her, ripping her clothes. [Client B] then sat down in the grass. [Client B] calmed and had no further behaviors."</p> <p>__The BDDS report indicated "Plan to Resolve (Immediate and Long Term). No one was injured during the incident. [Client B] has a history of leaving assigned area and physical aggression.</p>			

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	<p>Both are in [client B's] support plan and tracked. The team will continue to follow [client B's] support plan to reduce and prevent further incidents."</p> <p>The 8/15/15 IAR indicated at 11:20 AM "[Client B] was sitting on the front porch upset. He (client B) got more aggitated (sic) and ran out of the yard up the street into a yard. Staff followed closely. He then attacked staff, punching in the stomach and throwing sticks at them. After thirty minutes staff got [client B] redirected back to the house. He was calm for five minutes, got up (sic) ran out the back door trying to run out gate. Staff tried redirecting him. He attacked her and he scraped his left hand on the brick wall of house. He sat in yard for fifteen minutes then came in house and sat in his room."</p> <p>The 8/18/15 BDDS report indicated on 8/17/15 at 2 PM "[Client A] was in the kitchen with a staff member. Staff heard a loud sound and turned and noticed that [client A] had removed the pin from a fire extinguisher and squeezed the handle for a second. [Client A] let go and started saying it wasn't me. [Client A] assisted in cleaning up with no further incidents." __The BDDS report indicated "Plan to Resolve (Immediate and Long Term). No one was injured during the incident.</p>			

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	<p>[Name of fire extinguisher company] was notified about the extinguisher. [Client A] has a history of turning switches on and off. The team will continue to follow [client A's] support plan to help prevent and reduce further incidents."</p> <p>The 8/19/15 BDDS report indicated on 8/18/15 at 6:55 PM "[Client A] went to the medication room and became loud and threatened staff. [Client A] then grabbed the phone and ran out of the house. [Client A] ran to the police station that is at the end of [name of street the Community Alternatives Adept home was on] and highway [name of highway]. [Client A] was in staff's line of site (sic) that was catching up to him. [Client A] was at the police station door knocking on the door. Staff verbally redirected [client A]. [Client A] told the janitor that answered the door that he wanted the police and that he wants to die. [Client A] calmed and walked back to the house with staff. [Client A] sat at dining room table and started to color with staff. [Client A] got mad and ran past the staff that was with him and out the front door again. Staff followed and [client A] was in staff's line of sight. [Client A] made it to the police station again. Staff caught up and [client A] was out of breath and said he (client A) was ready to go home. [Client A] walked back home with staff</p>			

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	<p>and became verbally aggressive. [Client A] then began to turn over chairs and attempting (sic) to hit staff. Staff blocked and offered [client A] his coping mechanisms. [Client A] went to his room and began to calm."</p> <p>__The report indicated "Plan to Resolve (Immediate and Long Term). No one was injured during the incident. [Client A] has a history of running when upset, verbal and physical aggression. All behaviors are in his support plan and are tracked. The team will continue to follow the support plan to help prevent and reduce further incidents."</p> <p>The 8/24/15 IAR indicated at 6 AM client A was agitated and yelling at his house mates without reason and began "to get violent" with the staff. The staff asked him to go to his room to calm down and he tried to run toward the highway. Staff stayed with him and redirected him toward the house. The report indicated this happened twice and that client A had pulled the fire alarm three times. The report indicated client A finally calmed down around 11 AM.</p> <p>The 8/28/15 BDDS report indicated on 8/27/15 at 11:45 AM "[Client A] came out of the laundry room with a hat and scarf laughing. Staff laughed with him. [Client A] then went behind the staff</p>			

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	<p>sitting at the dining room table and put the scarf around staff's neck and started choking (the staff) while laughing. Staff blocked and acquired scarf explaining that what he did was not funny and could hurt someone. Staff was taking scarf to another room and client A came up behind staff and kicked him (the staff) between the legs in the groin area. Staff redirected [client A] to his room to help him calm down. Once in his room [client A] turned around and punched staff in the jaw. Staff blocked further attempt and another staff took over. [Client A] stayed in his room to calm and apologized to staff after he calmed."</p> <p>__The BDDS report indicated "Plan to Resolve (Immediate and Long Term). No one was injured during the incident. [Client A] has a history of physical aggression when upset and is in [client A's] support plan. [Client A] had a medication increase on 7-28-15 to help with increased aggressive behaviors. The team will continue to follow [client A's] support plan to help prevent and reduce further incidents."</p> <p>The 8/28/15 IAR indicated at 1:30 PM client A grabbed the phone and ran into the garage without turning on the lights. Client A ran into a shelf and cut his lip.</p> <p>The 8/29/15 BDDS report indicated on</p>			

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	<p>8/28/15 at 4:25 PM "[Client A] went for a walk with staff. [Client A] saw some kids playing and he (client A) grabbed his groin area while saying 'sexy baby.' Staff verbally redirected [client A] and he ran away from staff down the road. A car stopped and [client A] flipped the people in the car off (holding up a middle finger) and then grabbed his (client A's) groin area again while saying 'call me.' [Client A] continued to run from staff flipping off cars as they (the cars) went by him. Staff was within [client A's] site (sic) attempting to catch up to him. [Client A] made it to the [name of the police department] police station. [Client A] told a police officer there to arrest the staff, that they were being mean to him. The officer offered to take [client A] home in the squad car. Once in the car [client A] flipped off staff and then flipped switches turning on the lights and grabbed the radio talking on it. The officer and staff verbally redirected [client A] who then told them (the staff and the police officer) that he wanted to die. [Client A] went into the house and was making threats to hit staff and housemates. Staff offered coping mechanisms and [client A] sat down to write a letter."</p> <p>__The report indicated "Plan to Resolve (Immediate and Long Term). No one was injured during the incident. [Client A]</p>				

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	<p>has sexual inappropriateness and leaving assigned area in his behavior support plan. [Client A] was not out of staff's sight when he ran from staff. The team will continue to follow [client A's] support plan to help prevent and reduce further incidents."</p> <p>Review of an 8/18/15 email message from the BS to the PC and QIDP on 9/4/15 at 9 AM indicated "The IR (Incident Report) says there were only two staff on duty? That is not enough during waking hours for someone who can and does run. He (client A) has ADHD (Attention Deficit Hyperactivity Disorder). He does not stop. Staff did not follow the BSP. Med room was open/unlocked so he could walk in. After he ran out the door the first time, he was able to get out the door a second time. Who was supposed to be with him? Staff have to be within arms length of him when he is on the move. Staff did not follow the BSP. The police station is on [name of highway]. He got there twice. The staff was not within arms length and he could have ran (sic) into the street on either trip and been hit by a car and be dead. Saying that he was in line of sight did nothing but indicate the staff could see when he got hit by the cars. He got to the police station and talked to a janitor who I'm (the BS) sure will tell the police.</p>			

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	<p>And, since he's (client A) been there twice now, we should expect him to make regular visits since he is fixated on the police. While I don't believe the definition of what is reportable has changed per BDDS (any event characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual or death of an individual), it appears the general definition recognized by [name of facility] has as [client A] running to [name of highway] twice without staff close by would certainly seem to have the potential to result in significant harm, injury or death."</p> <p>Review of an email dated 8/16/15 from the BS to the QIDP on 9/4/15 at 9 AM indicated: "Not sure if [name of staff] called you yet or not. Some things to think about:</p> <p>__1. Apparently when she (the staff) arrived for her shift today, [client A] was in possession of a walkie talkie, the phone and flashlight from the emergency food supply and had reportedly by 2 PM today drank (sic) all six of the sodas he brought. Per [name of staff], when they tried to get those items from him since he wasn't supposed to have them, he got upset with them and he's all jacked up on six pops. I (the BS) talked to him and he wanted me to call the police on them,</p>			

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	<p>then said he wanted to die, called himself a b---t h--e then yelled at [client D] who was yelling about something else. He said he didn't want to talk to me and gave the phone to [name of staff]. I know this is partly the 2nd shift vs (versus)1st shift thing that always goes on. However, if [name of staff] is accurate, right now we need everyone to focus all their energy on staying one step ahead of [client A]. Neither you (the QIDP) or I (the BS) can tell them or write everything in a plan for them to do. We have to have faith they have some common sense. Just like the road is not for play neither are the walkies or phone. Whatever other food/drink he brought needs to be put up out of his sight and his access is to be per the menu. He won't be happy but in five minutes if redirected and with someone there to stay with him, he will move on to the next topic.</p> <p>__2. I (the BS) was there until 8:50 PM last night. I spent the majority of that time sitting with him talking, watching TV (television) and coloring and talking and talking in his bedroom and the living room outside his room. Within 45 minutes after I left, they decided to go sit outside on the front porch (even though this was after his shower, it was dark outside and time to wind down per his sleep protocol). [Name of staff] turns her head and he bolts toward the road and</p>			
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	<p>falls. Just like with the electronics, not having him outside in dark when you know he is going to take off, falls within the expectation of common sense. I am mindful that this is everyone's first day and they are used to the other guys. We need them to now take what they have learned and start engaging their brain for the entire shift. If they are unsure, they need to call."</p> <p>Review of an Internet note from the BS to the QIDP dated 5/7/15 on 9/4/15 at 9 AM indicated: "I'm (the BS) updating his (client A's) plan today to put a 30 day elopement protocol in place. He (client A) must be in line of sight at all times. His door is to remain open at all times unless there is a staff in his room with him - that includes bed time. We will re-evaluate in 30 days. That means staff must go and stay in his room with him if that door is shut. He will not like this but we have no other way right now to keep him safe since he knows how to turn off the alarms and can reach them. If [name of maintenance staff] can come up with some other method of alarms we can re-evaluate."</p> <p>Review of an email from the BS dated 10/15/14 on 9/4/15 at 9 AM indicated: "Staff have to move when [client A] moves. Every time. With three staff and</p>			

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	<p>four guys (clients), I know that leaves one of the guys free. It can't be [client A]. If he isn't going out a door to run down the street or through the field or chasing would-be criminals out of the back yard through the gate, he is going out and getting into unlocked staff cars and taking whatever he can grab. Or, he is going in a room, taking something that isn't his and either hiding it or throwing it away.... He is accomplished at turning off the door and window alarms as well as checking the med door to see if it is locked. He is a really busy guy."</p> <p>1. Client A's record was reviewed on 9/3/15 at 11 AM.</p> <p>Client A's revised 4/23/15 Behavior Support Plan (BSP) indicated client A had targeted behaviors of physical aggression, verbal aggression, property disruption/destruction, leaving his assigned area (elopement), false allegations or mistreatment, stealing and socially inappropriate behaviors.</p> <p>Client A's BSP indicated a definition of leaving his assigned area/elopement to be "Any time [client A] leaves an assigned area including areas in the home or areas where the group is at [(defined as the staff that are with him on a community outing)] without staff acknowledgement.</p>			

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	<p>This includes climbing out his alarmed window as well as walking out of the house to the front yard, the back yard or the garage without staff acknowledgement as well as entering housemate's bedrooms without permission."</p> <p>Client A's BSP indicated "STAFF ACTIONS: REACTIVE PROCEDURES Do not give [client A] anything or promise him anything to get him to stop a targeted behavior. Always initiate least restrictive alternatives first. Verbally redirect, physically redirect, block and move are the initial YSIS personal safety techniques to be used. YSIS Advanced techniques, such as one or two person holds or lifts, are only to be used as a last resort when necessary to prevent imminent injury to [client A] or others and after initial personal safety techniques have been attempted and proven unsuccessful."</p> <p>Client A's BSP indicated "Leaves assigned areas (out of bounds): __All staff on duty are to have access to charged walkie-talkies to use when [client A] exits the home and is out of bounds: any time [client A] leaves an assigned area including areas in the home or areas where the group is at [(defined as the staff that are with him on a</p>			

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	<p>community outing)] without staff acknowledgement. This includes climbing out his alarmed window as well as walking out of the house to the front yard, the back yard or the garage without staff acknowledgement as well as entering housemate's bedrooms without permission.</p> <p>__ If the window alarm from [client A's] bedroom window sounds, one staff should go immediately to [client A's] room and a second staff should go immediately outside to client A's window. If [client A] is attempting to open and climb out of his bedroom window, the inside staff will verbally redirect [client A] to talk to staff and stay in his room. If this is not successful, staff will physically redirect [client A] from the window, release and block his access to the window and if he persists, utilize a one person hold to keep him from the window. The outdoor staff will pull the window shut and be prepared to block [client A's] exit and then return to [client A's] room to assist with the intervention as needed.</p> <p>__ If [client A] attempts to exit the home through one of the exit doors that go to the street (front door or garage door) staff will attempt to block front and garage exits and physically redirect him from the door. If [client A] persists, staff will continue to block the door and verbally</p>			

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	<p>redirect [client A] to exit through the back door to the back yard.</p> <p>__If [client A] exits the back doors to the fenced back yard, one staff will remain outside in the yard with him to block him from climbing the fence and/or exiting through a gate and the other staff will be outside the fence blocking access through the gate.</p> <p>__If [client A] is outside the fence and attempts to leave the grounds walking, one staff will walk with [client A] and keep within arm's length of him (client A) at all times. The second staff will immediately notify the QIDP and follow the QIDP's instructions. Second staff will radio walking staff regarding instructions. Staff walking with [client A] will let him know that you are there to talk with him and help him problem solve what is upsetting him. Staff walking with [client A] will let him know that once he returns back to the home you and he will go in his room and will talk about what is upsetting him and help him come up with a solution. Once back at home and calm, talk with [client A] and help him problem-solve. Do not attempt to hurry [client A]. The more [client A] believes he is being hurried, the more he will resist. Be prepared to take your time.</p> <p>__If [client A] is running into the road [(name of road)]: Walking staff will insure [client A's] safety as well as</p>			

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	<p>his/her own safety by blocking him (client A) from approaching the road and going into oncoming traffic. Staff will implement You're Safe I'm Safe: Start with the least restrictive approach: physical redirect or escort, then one person YSIS. If he (client A) continues and becomes aggressive utilize the two person YSIS to ensure his safety. Be firm and direct asking [client A] to walk with you away from the road so that you and he can do (preferred activity).</p> <p>__ If [client A] is running into the road [(major highway or high traffic road: [name of highway])]. One staff will Immediately call 911 and then notify QIDP and follow QIDP's instructions. Walking staff will insure [client A's] safety as well as his/her own safety by blocking him from approaching the road and going into oncoming traffic. Staff will implement You're Safe I'm Safe. Start with the least restrictive approach: physical redirect or escort, then one person YSIS. If he continues and becomes aggressive utilize the two person YSIS to ensure his safety prior to him getting to the road. Be firm and direct asking [client A] to walk with you away from the road so that you and he can do [(preferred activity)].</p> <p>__ If [client A] is on the front or back porch. [Client A] must not be on the back (or front) porch without staff within arm's</p>			

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	<p>length of him. Direct [client A] to a chair positioned in a safe location on front porch and sit in a chair close to it. Do not rush [client A]. Be prepared to take the time to sit and talk or walk with him. Attempt to redirect him to preferred activities. If he makes an effort to go toward the fence, use YSIS to redirect him away from the fence while in the backyard. If he is able to make it to the fence and is able to climb the fence, remain in arms reach to prevent falling and prompt him to come down. Let him know that once he returns back to the home you and he will go in his room and will talk about what is upsetting him and help him come up with a solution.</p> <p>__If [client A] is in the garage. [Client A] is not to be in the garage without staff within arm's length of him. Let him know that once he returns back to the home you and he will go in his room and will talk about what is upsetting him and help him come up with a solution.</p> <p>__911 Emergency System may ONLY be used when individual behaviors jeopardize the safety and well-being of peers, community members and staff and ONLY when all Rescare-Indianapolis/ICF and Human Rights Committee approved de-escalation and redirection techniques have been utilized and exhausted. Clinical Supervisor/QIDP and Behaviorist are to</p>			

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	<p>be notified IMMEDIATELY once the call is placed. Upon arrival of emergency personnel, residential staff will intercede on behalf of the individual to coordinate police intervention, according to individual's current behavior status. If the individual is sitting or standing alone with no weapon, making no threats and causing no harm, staff must explain to emergency personnel the individual is not currently threatening and verbal intervention will be more beneficial than physical intervention."</p> <p>Client A's Modification of Individual's Rights (MOIR) last reviewed 7/15/15 indicated:</p> <p>__ Client A "demonstrated the lack of survival skills necessary to provide for client A's safety, welfare, security and health while in the community."</p> <p>__ "Community integration training will continue on an ongoing basis with emphasis on social boundaries and safety and the team will consider developing a formal objective in this area as other priority skills have been acquired."</p> <p>__ Client A "will be supervised during activities outside of the home."</p> <p>__ "[Client A] will have an alarm placed on his bedroom window, his living room windows and his living room back door which will sound when opened."</p> <p>__ "[Client A] may become excited or</p>			

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	<p>agitated and attempt to leave the home via his bedroom/living room window or door. In the process of doing so, [client A] may injure himself exiting through the window. Should he succeed in getting out of the window/door safely, [client A] poses a significant safety risk to himself as he has a history of running into the street and/or down the street with no regard for traffic, refusing to move for on-coming traffic, saying he wants to get hit by a car and die necessitating he be physically removed from the road."</p> <p>Client A's 2015 Monthly QMRP (Qualified Mental Retardation Professional) Summaries indicated: __ January 2015 - "[Client A] had an increase in aggressive behaviors in January. [Client A's] sleeping pattern has been abnormal. [Client A] will go to sleep after dinner and wake up around 2 am and stay awake. [Client A] will then lay back down around 9 am and sleep until lunch. Eat lunch and then go back to bed. [Client A's] psychiatrist is aware and will address at his upcoming appointment." __ February 2015 - "No significant changes. No new behavior noted. [Client A's] sleeping pill was increased to help with his sleeping pattern and another medication was moved from 4 pm to HS</p>			

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	<p>(bedtime) to see if that will help with his sleeping pattern. Death of a housemate and [client A] witnessed the event happen. [Client A's] mother stated to staff that she does not want him (client A) calling anymore."            ___ March 2015 - "No significant changes. No new behavior noted. [Client A's] sleeping pill was increased to help with his sleeping pattern and another medication was moved from 4 pm to HS to see if that will help with his sleeping pattern. Death of a housemate and [client A] witnessed the event happen. [Client A's] mother stated to staff that she does not want him (client A) calling anymore."            ___ No QIDP summary for April 2015.            ___ May 2015 - "There was a significant increase in behaviors this month. Due to this increase a new med (medication) was started to hopefully decrease aggression."            ___ June 2015 - "Behaviors continue to be high. [Client A's] attendance to workshop is decreasing. He (client A) says he would like to go and then disappears to his room until lunch."            ___ July 2015 - "Behaviors continue to be high. Increase in Geodon (an antipsychotic medication) at HS to attempt to help reduce behaviors."             Client A's Comprehensive Functional Assessment (CFA) dated 8/2014 indicated:</p>			

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	<p><u>  </u> Client A could not cross the street safely by himself.</p> <p><u>  </u> Client A shows no community safety awareness of dangers.</p> <p><u>  </u> Client A did not obey traffic signals and/or pedestrian cross/walk signals.</p> <p><u>  </u> Client A did not look both ways prior to crossing a street.</p> <p>Client A's Individualized Support Plan (ISP) dated 8/14/15 indicated no training objectives to assist client A with pedestrian safety while in the community.</p> <p>All of client A's IDT (Interdisciplinary Team) meeting notes from 10/1/14 to present were requested for review. No IDT notes were provided for review.</p> <p>2. Client B's record was reviewed on 9/3/15 at 11 AM. Client B's record indicated client B was admitted to the facility on 5/26/15.</p> <p>Client B's 5/26/15 BSP indicated client B had targeted behaviors of physical aggression, verbal aggression, property disruption/destruction, leaving his assigned area, inappropriate touch, and non compliance with program tasks.</p> <p>Client B's MOIR dated 5/26/15 indicated: <u>  </u> Client B demonstrated the lack of survival skills necessary to provide for</p>			

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	<p>client B's safety, welfare and health while in the community.</p> <p>___ "Community integration training will continue on an ongoing basis with emphasis on social boundaries and safety and the team will consider developing a formal objective in this area as other priority skills have been acquired."</p> <p>___ "[Client B] will become excited or agitated and attempt to leave the home via his bedroom window. In the process of doing so, [client B] may injure himself exiting through the window. Should he succeed in getting out of the window safely, [client B] poses a significant safety risk to himself and others as when agitated, he has a history of running into the street and/or down the street with no regard for traffic, refusing to move for on-coming traffic, requiring staff to block or physically remove him from the road."</p> <p>Client B's BSP indicated "Leaves Assigned Area: any time [client B] leaves a designated area without staff knowledge and permission including the home or area the group [(defined as the staff that is with him on a community outing)] is at."</p> <p>Client B's BSP indicated reactive strategies/procedures to be:</p> <p>___ "Do not give [client B] anything or promise him anything to get him to stop a</p>			

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	<p>behavior.</p> <p>__ Talking to and around [client B] at this point should be limited to what is necessary to implement the strategies.</p> <p>__ Extraneous conversations in front of him are just more noise, which can cause further escalation. STOP TALKING.</p> <p>__ Always initiate least restrictive alternatives first. Verbally redirect, physically redirect, block and move are the initial YSIS personal safety techniques to be used.</p> <p>__ YSIS Advanced techniques, such as one or two person holds or lifts are only to be used as a last resort when necessary to prevent imminent danger to [client B] or others and after initial personal safety techniques have been attempted. Imminent danger is defined as 'immediate danger which could reasonably be expected to cause death or serious physical harm'. Use of YSIS advanced techniques will be followed by assessment by a medical professional."</p> <p>Client B's BSP indicated the following reactive strategies when client B left his assigned area:</p> <p>__ "All staff on duty are to have a charged walkie-talkie on their person during the shift.</p> <p>__ Any time [client B] leaves a designated area without staff knowledge and permission including the home or areas</p>			

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	<p>the group [(defined as the staff that is with him on a community outing)] is at.</p> <p>___ If [client B] has left the house/grounds and is out of staff sight, immediately call 911.</p> <p>___ If staff observe [client B] attempting to leave, ask him to stay. Calmly prompt him to problem solve with you.</p> <p>___ If [client B] does as requested, briefly thank him and resume the ongoing activity with no further comment.</p> <p>___ If the window alarm from [client B's] bedroom window sounds, one staff will go immediately to [client B's] room and a second staff will go immediately outside to [client B's] window.</p> <p>___ If [client B] is attempting to open and climb out of his bedroom window, the inside staff will physically redirect him from the window, release and block his access to the window and if he persists, utilize a one person hold to keep him from the window. The outdoor staff will pull the window shut and be prepared to block [client B's] exit and then return to his room to assist with the intervention as needed.</p> <p>___ If [client B] attempts to exit the home through one of the exit doors that go to the street [(front door or garage door)] staff will attempt to block front and garage exits and physically redirect him from the door. If [client B] persists, staff will continue to block the door and</p>			

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	<p>verbally redirect [client B] to exit through the back door to the back yard.</p> <p>__If [client B] exits the back doors to the back yard, one staff will remain outside in the yard with him to block him from climbing the fence and/or exiting through a gate and the other staff will be outside the fence blocking access through the gate.</p> <p>__If [client B] is outside the fence and attempts to leave the grounds, staff will follow [client B] and initially keep a short distance between him and themselves (no more than 3 feet). Do not chase [client B], shadow him from behind and provide minimal attention. Immediately notify the QIDP and Behaviorist. Let the QIDP know what is going on and follow QIDP's instructions. Ask [client B] to stop walking and return home. At that first prompt, tell [client B] that once he returns back to the home you and he will talk about what is upsetting him and you'll help him come up with a solution.</p> <p>__If [client B] doesn't stop, continue to follow, provide minimal attention/conversation by prompting to stop ('[Client B], please stop and return home'.) every 5 minutes until he returns home.</p> <p>__When [client B] returns to the home and he is calm talk with him and help him problem solve.</p> <p>__If the area [client B] is trying to go to</p>			

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	<p>poses a risk of harm to himself or others block [client B], redirect using YSIS physical redirection or escort. If he persists, use YSIS one or two person hold.</p> <p>__911 Emergency System may only be used when: individual behaviors jeopardize the safety and well-being of peers, community members and staff and only when all ResCare and Human Rights Committee approved de-escalation and redirection techniques have been utilized and exhausted. QIDP and Behaviorist are to be notified immediately before the call is placed. Upon arrival of emergency personnel, residential staff will intercede on behalf of the individual to coordinate police intervention, according to individual's current behavior status. If the individual is sitting or standing alone with no weapon, making no threats and causing no harm, staff must explain to emergency personnel the individual is not currently threatening and verbal intervention will be more beneficial than physical intervention."</p> <p>Client B's CFA dated 5/26/15 indicated client B could not cross the street safely by himself.</p> <p>Client B's ISP dated 5/26/15 indicated no training objectives to assist client B with pedestrian safety while in the community.</p>			

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	<p>Client B's IDT meeting notes since admission was requested for review. No IDT notes were provided for review.</p> <p>During interview with staff #4 on 9/2/15 at 3:45 PM, staff #4:</p> <p>__ Stated, "There are three of us (staff) here usually and one of us has to watch [client A], one of us has to watch [client B] and one of us has to watch [client D]."</p> <p>__ Indicated clients A and B had behaviors of leaving the home unsupervised.</p> <p>__ Indicated it was hard for him to run after client A and stated, "He's slick."</p> <p>__ Stated, "At the bat of an eye he can slip out the door or all we have to do is turn around or take our eyes off him and he's out the door."</p> <p>__ Indicated the staff usually would stay in the general area with client A and keep him in eyesight.</p> <p>__ Indicated client A had gotten out of the house and to the highway several times and had tried to step in front of traffic and the staff had to pull him back when they caught up with him.</p> <p>__ Indicated client B was older and he didn't like all the noise and commotion and has had some difficulty adjusting to the changes.</p> <p>__ Indicated client B was not as fast as client A.</p>			

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	<p>During interview with staff #5 on 9/2/15 at 4 PM, staff #5:</p> <p>__ Indicated the staff were to stay nearby client A and were to keep client A within eyesight in case he was to run from the house.</p> <p>__ Indicated three staff worked the evening shift.</p> <p>__ Indicated one staff usually stayed with client A, one staff with client B and one staff with client D.</p> <p>__ Indicated client A was a fast runner and often would run out of the house before the staff could block him.</p> <p>__ Indicated he was aware of the alarms on the doors but was not certain which windows if any had alarms on them.</p> <p>During interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/3/15 at 1 PM, the QIDP:</p> <p>__ Indicated client A's admission date to the facility was 8/15/14 and stated, "He's (client A) been here a little over a year."</p> <p>__ Stated client A "Typically runs toward (name of highway)," a major busy highway.</p> <p>__ Indicated the local police department was located at the end of the road the group home was located and on the same major highway client A usually ran toward.</p> <p>__ Indicated client A has run in front of</p>			
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	<p>cars and cars have had to stop for client A on more than one occasion.</p> <p>__ Stated, "So far he hasn't gotten seriously hurt."</p> <p>__ Stated the staff were to closely supervise client A while in and out of the home and "should be within arms reach but he (client A) is just too fast. You've seen how fast he is."</p> <p>__ Stated originally there were alarms on all of the windows and all of the doors in the home but client A was "quick and sneaky" and figured out how to disarm and/or remove them.</p> <p>__ Indicated he did not know if alarms were still on all of the windows without going around and physically checking each one.</p> <p>__ Stated, "We just need to take them off (the window alarms). They're not working anyway."</p> <p>__ Indicated client A had attempted going out his window on a couple of occasions.</p> <p>__ Indicated there were alarms on all egress doors; the front door, both living room doors and the door going out to the garage.</p> <p>__ Stated the alarms were changed "some time ago" because client A figured out how to disarm the old ones.</p> <p>__ Indicated client A knows how to change and/or disable the sound on the door alarms.</p> <p>__ Indicated he (the QIDP) was not aware</p>			

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	<p>the door alarm on the back door by the QIDP's office was not functioning and missing one piece of the alarm until pointed out by this surveyor.</p> <p>__ When asked how the window and door alarms were to be monitored to ensure the alarms were present and functional, the QIDP stated, "I didn't think about that. I guess I should put something in place to make sure they're (the alarms) working?"</p> <p>__ When asked to see client A's IDT meeting notes the QIDP stated, "I know I should have been writing them (the IDT meeting notes) down. I'm so used to talking to [name of behavior specialist] and then I forget to document it."</p> <p>__ Indicated he was in frequent contact with the behavior specialist and client A's medications had been changed a couple of times.</p> <p>__ Indicated there had been no changes in client A's ISP/BSP in regard to client A's continued AWOLs (Absence Without Leave).</p> <p>__ Indicated there had been no changes in how staff were to supervise client A in the home in regard to client A's frequent AWOL attempts.</p> <p>__ When asked how the facility was going to ensure client A's safety due to continued AWOL behaviors and running into the road or busy highway, the QIDP stated, "I see what you mean."</p>			

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	<p>During interview with the Behavior Specialist (BS) on 9/3/15 at 1 PM, the BS:</p> <p>__ Indicated there had been no changes in client A's BSP in regard to how the staff were to supervise client A inside and/or outside the group home.</p> <p>__ Indicated client A had some medication changes due to being sleepy during the day and not wanting to sleep at night.</p> <p>__ Indicated the staff were to follow client A's BSP.</p> <p>__ Indicated there were to be alarms on all egress doors and client A's windows and the windows in the common areas of the home, living rooms and dining room.</p> <p>__ Indicated client A was to be within arms reach of staff at all times inside and outside of the home.</p> <p>__ Indicated the QIDP was in frequent communication with her in regard to all the clients.</p> <p>2. The facility failed to implement its policy and procedures to ensure the facility conducted an investigation and/or ensured a thorough investigation was conducted in regard to allegations of abuse for clients A, B and D. Please see W154.</p> <p>3. The facility failed to implement its policy and procedures to ensure the</p>			

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	<p>facility provided sufficient direct care staff to monitor/supervise and implement client C's program plans and to prevent recurring elopements for clients A and B. Please see W186.</p> <p>The facility's policies and procedures were reviewed on 9/2/15 at 2 PM. The 9/14/07 facility policy entitled "Abuse, Neglect, Exploitation" indicated:</p> <p>___ "Adept employees actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect and exploitation shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of Adept, Rescare, and local, state and federal guidelines."</p> <p>___ "Intimidation/emotional abuse: the act of failure to act that results or could result in emotional injury to an individual. The act of insulting or coarse language or gestures directed toward an individual that subject him/her to humiliation or degradation. Discouraging or inhibiting behavior by threatening both actual or implied. Attitude or acts that interfere with the psychological and social well being of an individual."</p> <p>___ "Emotional/physical neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide the support necessary to an individual's psychological and social well being. Failure to meet the basic need requirements such as food, shelter, clothing and to provide a safe environment."</p> <p>This federal tag relates to Complaint #IN00179008.</p> <p>9-3-2(a)</p>			

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W 0154  Bldg. 00	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 4 of 5 allegations of abuse reviewed, the facility failed to ensure all allegations of abuse were investigated and/or thoroughly investigated for clients A, B and D.</p> <p>Findings include:</p> <p>The facility reportable and investigative records were reviewed on 9/2/15 at 1 PM.</p> <p>1. The 8/29/15 BDDS report indicated on 8/28/15 at 4:25 PM "[Client A] went for a walk with staff. [Client A] saw some kids playing and he (client A) grabbed his groin area while saying 'sexy baby.' Staff verbally redirected [client A] and he ran away from staff down the road. A car stopped and [client A] flipped the people in the car off (holding up a middle finger) and then grabbed his (client A's) groin area again while saying 'call me.' [Client A] continued to run from staff flipping off cars as they (the cars) went by him. Staff was within [client A's] site</p>	W 0154	<p><b>CORRECTION:</b></p> <p><i>The facility must have evidence that all alleged violations are thoroughly investigated.</i></p> <p>Specifically: the Operations Team, including the Program Manager and Clinical Supervisor, will directly oversee all investigations. The QIDP will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews. The training will also stress the importance of assuring the investigative process determines if discovered injuries occurred as a result of staff negligence. The Clinical Supervisor and Program Manager will assure that conclusions are developed that match the collected evidence. When any evidence of staff negligence or mistreatment is uncovered or alleged the Operations Team will take control of all aspects of the investigation process. Specifically for Client A, the individual has a long history of making false and</p>	10/10/2015

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	<p>(sic) attempting to catch up to him. [Client A] made it to the [name of the police department] police station. [Client A] told a police officer there to arrest the staff, that they were being mean to him. The officer offered to take [client A] home in the squad car. Once in the car [client A] flipped off staff and then flipped switches turning on the lights and grabbed the radio talking on it. The officer and staff verbally redirected [client A] who then told them (the staff and the police officer) that he wanted to die. [Client A] went into the house and continued making threats to hit staff and housemates. Staff offered coping mechanisms and [client A] sat down to write a letter." The facility records indicated no investigation was conducted in regard to client A's allegation of staff being mean to client A.</p> <p>2. The 8/14/15 BDDS report indicated on 8/14/15 at 12:50 PM client D was walking through the house when client B pushed client D. __The investigative record did not indicate interviews and/or statements from all clients and all staff in the home at the time of the incident. The investigative record indicated no summary/outcome of the investigation and/or results taken in regard to the findings of the investigation.</p>		<p>unsubstantiated allegations of mistreatment which is addressed in his Behavior Support Plan. Staff and the QIDP will receive retraining toward proper implementation of the plan's reactive strategies to assure that all allegations of abuse, neglect, mistreatment or exploitation are investigated thoroughly.</p> <p><b>PREVENTION:</b></p> <p>A tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and the Executive Director. The Clinical Supervisor (Administrative level management) will meet with his/her facility management teams weekly to review the progress made on all investigations that are open for their homes. Residential Managers will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation</p>	

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	<p>3. The 8/5/15 BDDS report indicated on 8/5/15 at 12:16 PM client D was talking to staff in the office and client B came into the office and told client D to leave. Client B then pushed client D in the stomach with one hand hard enough to cause client D to take a step back but not fall. Staff stood between the clients to prevent further assault. The facility records indicated no investigation was conducted.</p> <p>4. The 6/2/15 BDDS report indicated on 6/1/15 at 5:02 PM client A was being loud, slamming doors and flipping off (holding up a middle finger) client B. Client B became angry and ran after client A scratching client A's neck. The staff intervened to prevent further assault. The facility records indicated no investigation was conducted.</p> <p>During interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/3/15 at 3 PM, the QIDP:            ___ Indicated all allegations of abuse were to be investigated.            ___ Stated, "I'm (the QIDP) a little behind on organizing my papers."            ___ The QIDP indicated he was not able to find an investigation for the client to client abuse of 8/5/15 and 6/2/15.            ___ Indicated no investigation was</p>		<p>for which they are responsible, within the five business day timeframe. The Clinical Supervisor will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. The Program Manager will also conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations. Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members.</p> <p><b>RESPONSIBLE PARTIES:</b>            QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

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W 0159 Bldg. 00	<p>conducted in regard to the allegation of abuse made by client A while at the police station on 8/29/15.</p> <p>This federal tag relates to Complaint #IN00179008.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, interview and record review for 2 of 2 sampled clients (A and B) and 2 additional clients (C and D), the facility failed to ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored the clients' active treatment programs.</p> <p>The QIDP failed to ensure the IDT (Interdisciplinary Team) met to discuss client A's and client B's continued elopements from the home. The QIDP failed to ensure all IDT meetings were documented in the clients' records for clients A and B.</p> <p>The QIDP failed to ensure the clients'</p>	W 0159	<p><b>CORRECTION:</b> <i>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Specifically, The QIDP has been retrained regarding the need to bring all elements of the interdisciplinary team together to develop additional supports in response to serious incidents including but not limited to elopement. The QIDP has also been retrained regarding the need to maintain written documentation of all interdisciplinary meetings. The Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than four direct support staff on duty between 6:00 AM and 10:00 PM to prevent elopement</i></p>	10/10/2015

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	<p>ISPs addressed the clients' identified training needs in regard to pedestrian safety skills for clients A and B.</p> <p>The QIDP failed to ensure the clients' ISPs included how the staff were to supervise/monitor clients A and B while inside the home, how the staff were to position themselves to prevent the clients from exiting the home via an egress door, how the staff were to supervise/monitor client A to ensure client A did not dismantle and/or break the window/door alarms, and how the staff were to monitor the alarms in the home to ensure the alarms were intact and functioning for clients A and B.</p> <p>The QIDP failed to ensure the staff provided client C with formal and informal training objectives when opportunity was available.</p> <p>The QIDP failed to obtain written informed consent for a restrictive program and interventions for client B.</p> <p>Findings include:</p> <p>1. The facility reportable and investigative records were reviewed on 9/2/15 at 1 PM.</p> <p>The 10/7/14 Bureau of Developmental</p>		<p>and provide for the safety of all clients. The interdisciplinary team will develop prioritized objectives for Client A and Client B to train them toward developing effective pedestrian safety skills. Through observation the team determined that this deficient practice did not affect additional clients. Behavior Support Plans for Client A and Client B will be revised to include assigning one to one supervision duties to specific staff on the day and evening shifts to assure consistent application of enhanced supervision. All staff have been retrained by the Behavioral Clinician regarding the need to position themselves between client A and B and exits as well as to assure that Client A and Client B do not disable or alter the functioning of the exit alarms and to notify a supervisor of any attempts to do so. Malfunctioning alarms will be repaired and/or replaced. Additionally, window alarms will be installed wherever they are not already present in common areas of the home. Staff will perform and document function checks of all alarms no less than once each shift and more frequently as needed. These inspections will include: assuring each alarm is operational, assuring the alarms have a uniform alert signal that can be easily distinguished from other sounds in the home and are loud enough to be heard over the</p>	

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	<p>Disabilities Services (BDDS) report indicated on 10/6/14 at 10:15 PM "[Client A] was sitting at the dining room table when he got up and ran out the front door. Staff followed and [client A] stopped at highway [name of highway]. Staff caught up and attempted to verbally redirect [client A] back to the house. [Client A] refused and for his (client A's) safety staff used YSIS (You're Safe I'm Safe - a physical hold used to control behavior) standing to his (client A's) side assiting (sic) him back to the house. Once back, [client A] went to bed without further incident."</p> <p>__The report indicated "Plan to Resolve (Immediate and Long Term). [Client A] has a history of running for no reason. [Client A] did not appear to be upset or angry when he ran. Due to his continued running he has an appointment with his psychiatrist (sic) moved up to this Thursday (10/9/14)."</p> <p>The 3/30/15 Incident/Accident Report (IAR) indicated at 6:33 PM "[Staff #3 and staff #1] were out front (of the house) with [client D]. [Client A] saw us, came outside with [staff #6]. We stood in doorway, [client A] took off running towards the stream. [Staff #1] went to get him [client A], his leg hit a stick and caused a scrape.... Staff stated, [client A] said 'PoPo (the police)' and made his</p>		<p>ambient level of noise throughout the house. All direct support staff will be retrained and receive ongoing face to face coaching from supervisors regarding the need to provide Client C with consistent, aggressive and continuous active treatment including but not limited to meal preparation, family style dining, other domestic skills and meaningful leisure activities. Client A's behavior support plan will be modified to include assign specific staff to maintain responsibility for enhanced supervision and prevent elopement. All staff will be trained toward proper implementation of the modified plan. Written informed consent for restrictive programs will be obtained from Client A's guardians. A review of facility support documents and Human Rights Committee records indicated that this deficient practice did not affect any additional clients.</p> <p><b>PREVENTION:</b> The agency will retrain QIDP regarding the need to develop necessary supports and measureable objectives to support clients toward independence. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will incorporate audits of support documents into visits and active treatment observations at the facility twice weekly for the next</p>	

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	<p>hand like a gun and went towards the tree. Therefore this not (sic) an elopement attempt but [client A] playing around. The team will continue to follow his support plan and encourage [client A] to use the back yard instead of the front to avoid running towards the road."</p> <p>The 4/26/15 BDDS report indicated on 4/25/15 at 8 PM "[Client A] was sitting at the dining room table and started to cry and say he wanted mom. [Client A] then got up and ran out the door. Staff verbally redirected to come back inside and [client A] became physically aggressive swinging an object he had at staff. Staff was able to block. [Client A was placed into a two person YSIS hold for safety where one staff was on each side (of client A). Client A spit at staff and attempted to bite.... [Client A] calmed after a couple of minutes and then the hold was released. [Client A] went inside without further incident."</p> <p>__The report indicated "Plan to Resolve (Immediate and Long Term). No one was injured during the incident. YSIS is approved in [client A's] support plan and no injuries or marks where (sic) noted from the hold. [Client A] has a history of running when upset. The team will continue to follow [client A's] support plan to help prevent and reduce further incidents."</p>		<p>30 days and weekly visits for an additional 60 days. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Director of Operations/General Manager will determine the level of ongoing support needed at the facility. The QIDP will submit schedule revisions to the Clinical Supervisor for approval prior to implementation. The agency will retrain QIDP regarding the need to develop necessary supports and measureable objectives to support clients toward independence. The QIDP has been retrained regarding the need to incorporate all relevant interventions into support plans based on ongoing assessment, review of incident and behavior documentation and interdisciplinary input. When guardians and healthcare representatives are unable to attend team meetings face to face, consent forms will be sent via postal mail for review and signature, along with a stamped envelope addressed to the facility. If consents are not returned to the facility in a timely manner via standard postal mail, the QIDP will send the forms to the appropriate legal representative via registered mail to assure the documents have been delivered and received. The QIDP has been retrained regarding the need to incorporate all relevant</p>				

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	<p>__The 4/25/15 IAR indicated it was 8 PM and client A was in his pajamas when he went outside and the temperature outside was 34 degrees Fahrenheit.</p> <p>The 5/5/15 BDDS report indicated on 5/4/15 at 4 PM "[Client A] came out of his bedroom pulling his pants and underwear down to his ankles. [Client A] started laughing and grabbed his private area and started running through the house asking everyone to look at his private area while attempting to run. Staff redirected [client A] that he was being inappropriate and to please pull his pants up. Before staff could reach [client A], he tripped over his pants and fell into his door frame. [Client A's] inner thigh had connected with the door frame and [client A] laid on the floor laughing. When the staff called the QIDP to inform him [client A] grabbed the phone from staff and ran out the front door. Staff followed and when they caught up to him he stopped running and returned to the house with staff."</p> <p>__The report indicated "Plan to Resolve (Immediate and Long Term). [Client A] had a 3 inch red area on his inner thigh from where he fell into the door frame. Staff is monitoring and no first aid was necessary. The team will continue to follow [client A's] support plan to help</p>		<p>interventions into support plans based on ongoing assessment, review of incident and behavior documentation and interdisciplinary input. The QIDP will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to meal preparation, family style dining, other domestic skills and meaningful leisure activities and implementation of behavior supports. Members of the Operations Team and the QIDP will conduct observations during active treatment sessions no less than twice weekly for the next 30 days, and no less than weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as: Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts. Evenings: Beginning at approximately 4:30</p>	

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	<p>prevent and reduce further occurrences." __The 5/7/15 Follow Up BDDS report indicated "[Client A] was not out of staff's line of sight. [Client A's] male peers did see [client A] exposing himself they where (sic) in the living room. [Client A's] pants where (sic) pulled up prior to running out the door. Leaving assigned area and sexual inappropriateness (sic) are addressed in [client A's] support plan. The team will continue to follow [client A's] support plan to help prevent and reduce further incidents."</p> <p>The 5/7/15 BDDS report indicated on 5/7/15 at 7:35 AM "[Client A] was in his bedroom on the phone talking and was upset asking to move out and for his mom. Staff heard a school bus honking and staff went outside and the bus driver thought one of the individuals was walking down the road. Staff saw [client A] walking towards highway [name of highway] and caught up with [client A] at the [name of police] station which is less than 100 yards from site (sic). [Client A] returned to the house without incident."</p> <p>The 5/18/15 IAR indicated at 5:45 PM "[Client A] got mad because he said he wants to run outside. Started hitting elbow and hand on bedroom window repeatedly yelling, 'I want to run. I want</p>		<p>PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time. In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered. The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Administrative oversight at the facility will include but not be limited to: 1. Assuring that interdisciplinary team meetings occur and are documented as needed and in response to significant incidents. 2. Assuring appropriate supports are included in each client's support plan. 3. Direct face to face assessment of clients to compare observed behaviors and needs with current support documents and making recommendations for revisions as appropriate. 4. Assuring</p>	

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	<p>to die'."</p> <p>The 5/19/15 IAR indicated at 3:13 PM "[Client A] followed the staff outside while staff went to get a sweater out of car. As we (staff and client A) were coming inside, he (client A) acted like the 'PoPo' and took off towards the creek. Staff ran after him, tried to stop him from running through the creek. He (client A) went knees first, no injury noted, he came inside and is ok, left knee is a little red."</p> <p>The 5/26/15 BDDS report indicated on 5/26/15 at 1:05 PM "[Client B] moved in at noon and was upset about moving. [Client B] walked out the front door a total of five times attempting to walk home. [Client B] was never out of staff site (sic). The fourth time he walked out [client B] tripped on the terrain of the side of the road and landed on his right knee. [Client B's] right knee was skinned one inch in diameter and bleed slightly. All times that [client B] walked out he came back with verbal redirection. [Client B] was physically aggressive on the time he fell attempting to punch staff, but no one was injured."</p> <p>The 5/27/15 BDDS report indicated on 5/27/15 at 11 AM "[Client B] ran out the front door towards the road not leaving staff's line of sight. Staff caught up to</p>		<p>adequate direct support staff are on duty to meet the needs of all clients. 5. Assuring continuous active treatment occurs with all clients. 6. Assuring prior written informed consent has been obtained for all restrictive programs. <b>RESPONSIBLE PARTIES:</b> QIDP, Behavioral Clinician, Direct Support Staff, Operations Team, Director of Operations/General Manager</p>	

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	<p>[client B] to verbally redirect him to the house and he became physically aggressive toward staff attempting to hit and kick. [Client B] was verbally aggressive saying 'I will kill you; I will slit your throat.' Staff was able to block and gave [client B] time to calm. [Client B] returned to the house and started throwing chairs at staff and making threats. Staff applied a two person YSIS hold for safety where one staff stood on each side of [client B] with one hand on his wrist and the other arm around his waist. The hold was released after two minutes the staff talked to [client B] and was calm without further incident."</p> <p>The 6/2/15 BDDS report indicated on 6/2/15 at 9 AM "[Client B] was resting in his room. Staff member went to move their car and noticed [client B] walking on the road and went to catch up to him. Staff alerted coworkers and another staff went to assist. [Client B] returned with staff and attempted to walk out the door. Staff blocked and [client B] became verbally aggressive threatening (sic) to stab and cut staff. [Client B] became physically aggressive attempting to hit and kick staff. Staff where (sic) able to block. This lasted on and off for about an hour. Staff offered choices [(music, talking)] to help [client B] calm during the incident. [Client B] finally calmed</p>			

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	<p>and sat with staff and watched television."</p> <p>The 6/16/15 IAR indicated at 6:10 AM client A "took off out the front door" toward the driveway while the 3rd shift staff was leaving. The staff tried to stop him but was unable to and client A "ran into a staff's truck." The staff caught him as he was falling and client A got up and chased the staff as they were leaving. Client A calmed down and returned inside the home."</p> <p>The 6/30/15 BDDS report indicated on 6/29/15 at 3:30 PM "[Client B] walked out the back door and staff followed to keep him in sight. Staff sat down next to [client B] and [client B] grabbed at staff's clothing. Staff blocked and [client B] continued to grab at staff. Another staff member came out to assist and verbal (sic) redirected [client B] who then became physically aggressive towards that staff member. Staff member placed [client B] into a one person YSIS hold [(one person standing restraint)] for less than a minute by standing next to [client B] and placed one hand on his wrist to prevent him from punching. [Client B] calmed and hold was released. [Client B] apologized and had no further incidents."</p> <p>The 7/6/15 IAR indicated at 7 PM client</p>			

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	<p>A ran out the front door to the back yard wooded area in sight of staff. Client A was directed back into the house and he sat down on the couch. Client A then tried to run out the back door. The staff talked to client A and calmed him down.</p> <p>The 7/7/15 IAR indicated at 5 PM client A heard thunder and ran out of the house into the front yard and stood in the rain. The report indicated the staff directed client A to come back into the house and client A ran into the house, slipped and fell and obtained red marks on his right elbow and left knee.</p> <p>The 7/15/15 IAR indicated at 6:08 PM client A "eloped out the front door as staff was leaving." The report indicated client A headed to the back of the house around the garage and staff followed him trying to redirect him. Client A slipped on the wet grass and fell. Client A returned to the inside of the house.</p> <p>The 7/15/15 IAR indicated at 7:20 PM client A was yelling he wanted his mother and that he wanted to die. Client A started cursing at his house mates and the staff saying "Die, die. I want to die." Client A ran out of the front door and down the street toward a major highway. The staff ran after client A and grabbed client A by the shirt to stop him from</p>			

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	<p>running into oncoming traffic.</p> <p>The 7/17/15 BDDS report indicated on 7/16/15 at 6:23 PM "[Client B] was in the kitchen and a staff came into work. [Client B] went out the front door and slammed it. [Client B] started to run, yelling at staff to go home. Staff caught up to him and attempted to verbally redirect him to the house. [Client B] fell in the ditch beside the road and scraped his right cheek and a scrape on right knee. [Client B] went back to the house with staff with no further incidents."</p> <p>The 7/24/15 BDDS report indicated on 7/24/15 at 4:30 AM (sic - PM) "[Client A] ran around the car and kept running towards highway [name of highway]. Staff was running after and two cars had turned off of [name of highway] onto [name of road of group home] road. [Client A] was running down the road on the same side as the car and did not stop even though he could see the cars coming at him. The cars stopped and staff was able to catch up to [client A] before he reached highway [name of highway] by grabbing a hold of his hoodie (a sweatshirt). [Client A] stopped and staff immediately let go and walked back to the house with [client A]. Once back in the house [client A] became verbally aggressive toward staff and physically</p>			

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	<p>aggressive, attempting to punch staff. Staff blocked and [client A] started to fall backwards after swinging. Staff reached out to help prevent [client A] from falling by taking ahold (sic) of his shirt which ripped, but [client A] did not fall. Staff immediately let go and [client A] grabbed a chair throwing it at staff that blocked. Staff continued to offer coping mechanisms and [client A] went to his room where he calmed with no further incidents."</p> <p>The 8/2/15 BDDS report indicated on 8/2/15 at 5:35 PM "[Client B] ran out the back door. He (client B) came back inside and appeared to have calmed down. He ran a second time towards the back gate when he fell on the step, landing on his right knee and right hand. He calmed down and came back inside the house."</p> <p>The 8/13/15 BDDS report indicated on 8/13/15 at 10:30 AM "[Client B] returned from a doctor's appointment and told staff that he was going to run. Staff followed [client B] out the front door and where (sic) able to verbally redirect him back to the house. Once back in the house [client B] became physically aggressive and attempted to punch staff. [Client B] also attempted to kick and throw objects at staff. Staff was able to</p>			

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	<p>block. [Client B] apologized to staff and said that he was going to his room to calm down. Near his room he grabbed a card table and flipped it and said he was going to run. [Client B] then went out the back door and slammed it shut holding it closed. Staff went out the other door and [client B] swung at staff missing. [Client B] pushed staff attempting to go out the back gate. Staff attempted to redirect and [client B] grabbed the staff, throwing her ripping her clothes. [Client B] then sat down in the grass. [Client B] calmed and had no further behaviors."</p> <p>The 8/15/15 IAR indicated at 11:20 AM "[Client B] was sitting on the front porch upset. He (client B) got more aggitated (sic) and ran out of the yard up the street into a yard. Staff followed closely. He then attacked staff, punching in the stomach and throwing sticks at them. After thirty minutes staff got [client B] redirected back to the house. He was calm for five minutes, got up, ran out the back door trying to run out gate. Staff tried redirecting him. He attacked her and he scraped his left hand on the brick wall of house. He sat in yard for fifteen minutes then came in house and sat in his room."</p> <p>The 8/19/15 BDDS report indicated on 8/18/15 at 6:55 PM "[Client A] went to</p>			

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	<p>the medication room and became loud and threatened staff. [Client A] then grabbed the phone and ran out of the house. [Client A] ran to the police station that is at the end of [name of street the Community Alternatives Adept home was on] and highway [name of highway]. [Client A] was in staff's line of site (sic) that was catching up to him. [Client A] was at the police station door knocking on the door. Staff verbally redirected [client A]. [Client A] told the janitor that answered the door that he wanted the police and that he wants (sic) to die. [Client A] calmed and walked back to the house with staff. [Client A] sat at dining room table and started to color with staff. [Client A] got mad and ran past the staff that was with him and out the front door again. Staff followed and [client A] was in staff's line of sight. [Client A] made it to the police station again. Staff caught up and [client A] was out of breath and said he (client A) was ready to go home. [Client A] walked back home with staff and became verbally aggressive. [Client A] then began to turn over chairs and attempting (sic) to hit staff. Staff blocked and offered [client A] his coping mechanisms. [Client A] went to his room and began to calm."</p> <p>The 8/24/15 IAR indicated at 6 AM client A was agitated and yelling at his</p>			

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	<p>house mates without reason and began "to get violent" with the staff. The staff asked him to go to his room to calm down and he tried to run toward the highway. Staff stayed with him and redirected him toward the house. The report indicated this happened twice and that client A had pulled the fire alarm three times. The report indicated client A finally calmed down around 11 AM.</p> <p>The 8/28/15 IAR indicated at 1:30 PM client A grabbed the phone and ran into the garage without turning on the lights. Client A ran into a shelf and cut his lip.</p> <p>The 8/29/15 BDDS report indicated on 8/28/15 at 4:25 PM "[Client A] went for a walk with staff. [Client A] saw some kids playing and he (client A) grabbed his groin area while saying 'sexy baby.' Staff verbally redirected [client A] and he ran away from staff down the road. A car stopped and [client A] flipped the people in the car off (holding up a middle finger) and then grabbed his (client A's) groin area again while saying 'call me.' [Client A] continued to run from staff flipping off cars as they (the cars) went by him. Staff was within [client A's] site (sic) attempting to catch up to him. [Client A] made it to the [name of the police department] police station. [Client A] told a police officer there to arrest the</p>			

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	<p>staff, that they were being mean to him. The officer offered to take [client A] home in the squad car. Once in the car [client A] flipped off staff and then flipped switches turning on the lights and grabbed the radio talking on it. The officer and staff verbally redirected [client A] who then told them (the staff and the police officer) that he wanted to die. [Client A] went into the house and making threats to hit staff and housemates. Staff offered coping mechanisms and [client A] sat down to write a letter." __The report indicated "Plan to Resolve (Immediate and Long Term). No one was injured during the incident. [Client A] has sexual inappropriateness and leaving assigned area in his behavior support plan. [Client A] was not out of staff's sight when he ran from staff. The team will continue to follow [client A's] support plan to help prevent and reduce further incidents."</p> <p>Client A's record was reviewed on 9/3/15 at 11 AM. Client A's record indicated no IDT meeting notes.</p> <p>Client B's record was reviewed on 9/3/15 at 1 PM. Client B's record indicated no IDT meeting notes.</p>			

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	<p>During interview with the BS on 9/3/15 at 1:15 PM, the BS indicated she would go through her emails and would send what information she had on client A.</p> <p>Review of the 9/3/15 10:50 PM email from the BS on 9/4/15 at 9 AM indicated a summary of the BS's emails in regard to client A: "From my notes here is a list of dates and topics of discussions involving myself (the BS), [name of QIDP], [name of CS (Clinical Supervisor)], LPM (Lead Program Manager), guardians [name of guardians] for the last 6 months.</p> <p>2/4/15: [Client A's] status on community activity from [name of QIDP]. [Client A] did well out at [name of department store] with [name of QIDP] one day and with staff [name of staff] the next. Was compliant but tended to get sleepy helping with grocery shopping.</p> <p>3/23/15: Discussion of neurobehavior specific to fetal alcohol syndrome training information with [name of CS]) and [name of QIDP] emphasizing importance of keeping [client A] redirected and engaged to reduce target behaviors.</p> <p>5/7/15: Discuss 30 day elopement protocol in BSP following [client A] turning off window alarms and</p>			

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	<p>exiting. Discuss with [name of QIDP] and plan sent to guardian for approval.</p> <p>5/11/15: suggest to [name of QIDP] and nurse an appointment with ENT (Ears Nose and Throat physician) regarding possible inner ear issues since [client A] complains of spinning in his head and does not consistently maintain balance when running.</p> <p>6/2/15: discussion with [name of QIDP] the reasons [client B] and [client A] should not be in kitchen at same time. Too small a space, [client B] doesn't like people close to him and [client A] loud volume.</p> <p>6/23/15: discussion with [name of QIDP] [client A's] focus on a specific female staff .</p> <p>7/13/15: following investigation, review with [name of QIDP, name of PC, name of LPM (Lead Program Manager)] - [client A's] needs [(including targeted behaviors)] and what can be done to help him be successful and safe.</p> <p>8/17/15: discussion with [name of QIDP] regarding circumstances surrounding [client A's] incident with fire extinguisher</p> <p>8/24/15: discussion with [name of QIDP] regarding contacting [client A's]</p>			

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	<p>psychiatrist d/t (due to) increased targeted behavior.</p> <p>8/31/15: discussion with and [name of QIDP] and nurse regarding effects of caffeine on [client A] and suggested possible follow up with PCP (Primary Care Physician) and dietician."</p> <p>During interview with the QIDP on 9/3/15 at 1 PM, the QIDP:            __ When asked what changes have the IDT made to ensure client A's and client B's safety in regard to their recurring behavior of leaving the home and running to a nearby busy highway, the QIDP stated, "Well, I know there were some med changes."            __ Indicated no IDT meeting notes were documented and/or available for review.            __ Indicated he (the QIDP) had a few emails that were sent to the BS (Behavior Specialist) but he would have to look for them.            __ The QIDP stated, "I know I should have been writing them (the IDT meeting notes) down. I'm so used to talking to [name of BS] and then I forget to document it."</p> <p>2. The QIDP failed to ensure sufficient staff were in the home to monitor/supervise and implement the clients' program plans and to prevent</p>			

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	<p>recurring elopements for clients A, B, C and D. Please see W186.</p> <p>3. The QIDP failed to ensure the clients' ISPs addressed the clients' identified training needs in regard to pedestrian safety skills for clients A and B. Please see W227.</p> <p>4. The QIDP failed to ensure the clients' ISPs included how the staff were to supervise/monitor clients A and B while inside the home, how the staff were to position themselves to prevent the clients from exiting the home via an egress door, how the staff were to supervise/monitor client A to ensure client A did not dismantle and/or break the window/door alarms, and how the staff were to monitor the alarms in the home to ensure the alarms were intact and functioning for clients A and B. Please see W240.</p> <p>5. The QIDP failed to ensure the staff provided client C with formal and informal training objectives when opportunity was available. Please see W249.</p> <p>6. The QIDP failed to obtain written informed consent for a restrictive program and interventions for client B. Please see W263.</p>			

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W 0186 Bldg. 00	<p>This federal tag relates to Complaint #IN00179008.</p> <p>9-3-3(a)</p> <p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, record review and interview for 4 of 4 clients living in the group home (A, B, C and D), the facility failed to provide sufficient direct care staff to monitor/supervise and implement the clients' program plans and to prevent recurring elopements for client A.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 9/2/15 between 3:30 PM and 5 PM.</p> <p>__ There were three direct care staff in the home with four male clients (A, B, C and D).</p> <p>__ The group home was a single level brick home with four bedrooms, a dining</p>	W 0186	<p><b>CORRECTION:</b></p> <p><i>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Specifically, the Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than four direct support staff on duty between 6:00 AM and 10:00 PM to prevent elopement and provide for the safety of all clients.</i></p> <p><b>PREVENTION:</b></p> <p>The QIDP will submit schedule</p>	10/10/2015	

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	<p>room, two living/entertainment rooms and an attached garage.</p> <p>__ The home was located 0.2 miles (352 yards) from a major highway.</p> <p>__ The back door opened onto a small patio/area with a tall privacy fence and a gate.</p> <p>__ There were alarmed egress doors in the dining room (the front door), the small living room (the side door), the large living room (the back door) and the garage door.</p> <p>__ Client A was a young male that was loud, was in constant motion, was fast on his feet and was invasive of his peers' and the staffs' personal space.</p> <p>__ Client B was a quiet older male that was short in stature, had a slight forward lean and ambulated at a moderate pace.</p> <p>__ Client C was an older tall average size male who wore baggy clothing and had a full scraggly beard and long thinning hair that stuck together in clumps and who kept mostly to himself.</p> <p>__ Client D was a tall, quiet, large and active young male.</p> <p>At 3:30 PM:</p> <p>__ Client A escorted this surveyor around his home starting with his bedroom.</p> <p>__ Staff #5 walked near by client A throughout the home.</p> <p>__ Client A's bedroom had two large windows.</p>		<p>revisions to the Clinical Supervisor for approval prior to implementation.</p> <p>Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, will conduct observations during active Treatment sessions and documentation reviews no less than twice weekly for the next 30 days, and no less than weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p>	

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	<p>__ Client A walked to the garage and pointed out his desk and furniture that used to be in his room but was now broken. Staff #5 indicated it was no longer in the garage because client A had broken his desk and dresser.</p> <p>__ Client A pointed out alarms on the doors and the windows and indicated he could turn the alarms off, change the sounds and/or take the alarms down down.</p> <p>__ Client A walked to the main bathroom and pointed out how the toilet was not working properly. Client A put both arms around the toilet bowl and began shifting the toilet up and sideways from the base of the floor.</p> <p>__ Staff #5 indicated client A had broken the toilet and they were waiting for maintenance to fix it.</p> <p>__ Client A's behaviors began to escalate. Client A got louder and began cursing at the staff, telling the staff to "shut up" while darting in and around the staff and other clients that were nearby.</p> <p>__ At 4:05 PM, client A lunged toward the QIDP. Due to client A's escalating behaviors, staff #5 suggested to client A that he go outside with staff #5 to play basketball or to sweep the sidewalk. Staff #5 and client A went outside.</p> <p>__ At 5 PM the clients prepared to sit down to eat their evening meal. Client A was darting in and around the table,</p>		<p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility.</p>	

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	<p>pouring drinks when he was asked not to, switching the dinnerware around and was telling the staff and his peers to shut up.</p> <p>During this observation period:            ___Staff #5 remained nearby client A, interacting and redirecting client A constantly.            ___Staff #6 remained nearby client B. Staff #6 and client B walked outside, helped set the table for the evening meal, interacted and talked.            ___Staff #4 remained nearby client D. Staff #4 and client D were in and out of the kitchen preparing the evening meal, walked outside, were in and out of client D's bedroom with staff #4 redirecting client D as needed due to behaviors.            ___Client C sat alone in the living room near the back door in a small straight chair watching television and occasionally getting up to go sit outside to the fenced in patio area.            ___Client C did not talk and/or interact with those around him unless spoken to.            ___Client C's bedroom was disheveled with clothing and trash thrown around on the bed, floor and dresser. The remains of the wrapper from a large package of cookies lay on the floor.            ___Client C sat in the back living room from 3:30 PM until 5 PM at which time client C was directed to come to the dining room table for the evening meal.</p>		<p>Administrative support at the home will include assuring adequate direct support staff are on duty to meet the needs of all clients.</p> <p>The Clinical Supervisor will perform periodic spot checks of attendance records to assure ongoing compliance. Prior to each schedule period, the Operations Team will follow-up verbally and via email to assure that appropriate coverage has been arranged.</p> <p><b>RESPONSIBLE PARTIES:</b>            QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

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	<p>Observations were conducted at the group home on 9/3/15 between 4 PM and 5 PM. During this observation period:</p> <p>__ There were three direct care staff and four clients, (clients A, B, C and D).</p> <p>__ One staff remained nearby client A, one staff remained nearby client B and one staff remained nearby client D.</p> <p>__ Client C sat alone in the living room near the back door in a small straight chair watching television and occasionally getting up to go sit outside in the fenced in patio area.</p> <p>__ Client C did not talk and/or interact with those around him unless spoken to.</p> <p>__ At 4 PM client C was outside in the patio area. Client C opened the door, saw this surveyor and the QIDP and immediately backed out of the doorway, shut the door and returned to the patio area outside. After a few minutes client C reopened the door, looked to see that no one was nearby and then entered the living room. Client C sat down in the straight chair where he had been sitting before and began watching television.</p> <p>The facility reportable and investigative records were reviewed on 9/2/15 at 1 PM.</p> <p>The 10/7/14 Bureau of Developmental Disabilities Services (BDDS) report indicated on 10/6/14 at 10:15 PM</p>			

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	<p>"[Client A] was sitting at the dining room table when he got up and ran out the front door. Staff followed and [client A] stopped at highway [name of highway]. Staff caught up and attempted to verbally redirect [client A] back to the house. [Client A] refused and for his (client A's) safety staff used YSIS (You're Safe I'm Safe - a physical hold used to control behavior) standing to his (client A's) side assiting (sic) him back to the house. Once back, [client A] went to bed without further incident."</p> <p>The 3/30/15 Incident/Accident Report (IAR) indicated at 6:33 PM "[Staff #3 and staff #1] were out front (of the house) with [client D]. [Client A] saw us, came outside with [staff #6]. We stood in doorway, [client A] took off running towards the stream. [Staff #1] went to get him [client A], his leg hit a stick and caused a scrape.... Staff stated, [client A] said 'PoPo (the police)' and made his hand like a gun and went towards the tree. Therefore this not (sic) an elopement attempt but [client A] playing around. The team will continue to follow his support plan and encourage [client A] to use the back yard instead of the front to avoid running towards the road."</p> <p>The 4/26/15 BDDS report indicated on 4/25/15 at 8 PM "[Client A] was sitting at</p>			

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	<p>the dining room table and started to cry and say he wanted mom. [Client A] then got up and ran out the door. Staff verbally redirected to come back inside and [client A] became physically aggressive swinging an object he had at staff. Staff was able to block. [Client A] was placed into a two person YSIS hold for safety where one staff was on each side (of client A). Client A spit at staff and attempted to bite.... [Client A] calmed after a couple of minutes and then the hold was released. [Client A] went inside without further incident."</p> <p>__The 4/25/15 IAR indicated it was 8 PM and client A was in his pajamas when he went outside and the temperature outside was 34 degrees Fahrenheit.</p> <p>The 5/5/15 BDDS report indicated on 5/4/15 at 4 PM "[Client A] came out of his bedroom pulling his pants and underwear down to his ankles. [Client A] started laughing and grabbed his private area and started running through the house asking everyone to look at his private area while attempting to run. Staff redirected [client A] that he was being inappropriate and to please pull his pants up. Before staff could reach [client A], he tripped over his pants and fell into his door frame. [Client A's] inner thigh had connected with the door frame and [client</p>			

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	<p>A] laid on the floor laughing. When the staff called the QIDP to inform him [client A] grabbed the phone from staff and ran out the front door. Staff followed and when they caught up to him he stopped running and returned to the house with staff."</p> <p>The 5/7/15 BDDS report indicated on 5/7/15 at 7:35 AM "[Client A] was in his bedroom on the phone talking and was upset asking to move out and for his mom. Staff heard a school bus honking and staff went outside and the bus driver thought one of the individuals was walking down the road. Staff saw [client A] walking towards highway [name of highway] and caught up with [client A] at the [name of police] station which is less than 100 yards from site (sic). [Client A] returned to the house without incident."</p> <p>__The Elopement/Missing Person Investigation Summary dated 5/7/15 indicated: Client A "must have slipped out the back door by his room (bedroom)." Client A was able to turn off the door alarm by himself. Client A was discovered walking on the street in front of the group home and was headed toward a busy highway. The staff realized the client was gone</p>			

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	<p>when they heard the bus driver honking the horn.</p> <p>Client A knew how to disarm the door alarms.</p> <p>__The 5/7/15 Confidential Witness Statement Form (CWSF) from staff #3 indicated client A had asked to call the Behavior Clinician (BC) and had taken the phone to his bedroom. Staff #3 indicated he began preparing client A's record for an appointment. "A couple min (minutes) pas (sic) I (staff #3) heard bus driver out front honking. [Staff #7] and I (staff #3) went outside. Driver (bus driver) said, 'I think one of your guys got away.' I looked towards [name of highway] and observe (sic) [client A] walking toward police station and I took off on foot after him."</p> <p>__The 5/7/15 CWSF from staff #7 indicated staff #3 chased after client A on foot and staff #7 got the keys and followed in the facility van.</p> <p>The 5/18/15 IAR indicated at 5:45 PM "[Client A] got mad because he said he wants to run outside. Started hitting elbow and hand on bedroom window repeatedly yelling, 'I want to run. I want to die'."</p> <p>The 5/19/15 IAR indicated at 3:13 PM "[Client A] followed the staff outside while staff went to get a sweater out of</p>			

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	<p>car. As we (staff and client A) were coming inside, he (client A) acted like the 'PoPo' and took off towards the creek. Staff ran after him, tried to stop him from running through the creek. He (client A) went knees first, no injury noted, he came inside and is ok, left knee is a little red."</p> <p>The 5/26/15 BDDS report indicated on 5/26/15 at 1:05 PM "[Client B] moved in at noon and was upset about moving. [Client B] walked out the front door a total of five times attempting to walk home. [Client B] was never out of staff site (sic). The fourth time he walked out [client B] tripped on the terrain of the side of the road and landed on his right knee. [Client B's] right knee was skinned one inch in diameter and bleed slightly. All times that [client B] walked out he came back with verbal redirection. [Client B] was physically aggressive on the time he fell attempting to punch staff, but no one was injured."</p> <p>The 5/27/15 BDDS report indicated on 5/27/15 at 11 AM "[Client B] ran out the front door towards the road not leaving staff's line of sight. Staff caught up to [client B] to verbally redirect him to the house and he became physically aggressive toward staff attempting to hit and kick. [Client B] was verbally aggressive saying 'I will kill you; I will</p>			

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	<p>slit your throat.' Staff was able to block and gave [client B] time to calm. [Client B] returned to the house and started throwing chairs at staff and making threats. Staff applied a two person YSIS hold for safety where one staff stood on each side of [client B] with one hand on his wrist and the other arm around his waist. The hold was released after two minutes the staff talked to [client B] and was calm without further incident."</p> <p>The 6/2/15 BDDS report indicated on 6/2/15 at 9 AM "[Client B] was resting in his room. Staff member went to move their car and noticed [client B] walking on the road and went to catch up to him. Staff alerted coworkers and another staff went to assist. [Client B] returned with staff and attempted to walk out the door. Staff blocked and [client B] became verbally aggressive threatening (sic) to stab and cut staff. [Client B] became physically aggressive attempting to hit and kick staff. Staff where (sic) able to block. This lasted on and off for about an hour. Staff offered choices [(music, talking)] to help [client B] calm during the incident. [Client B] finally calmed and sat with staff and watched television."</p> <p>__The BDDS report indicated: "Plan to Resolve (Immediate and Long Term). No one was injured during the incident.</p>			

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	<p>[Client B] was out of staff site (sic) for two minutes and had left through the back door and out the gate in back yard. One staff was in the other living room with a housemate, one staff was in the medication room faxing and the other staff was at the dining room table getting a housemate their daily finances."</p> <p>The 6/16/15 IAR indicated at 6:10 AM client A "took off out the front door" toward the driveway while the 3rd shift staff was leaving. The staff tried to stop him but was unable to and client A "ran into a staff's truck." The staff caught him as he was falling and client A got up and chased the staff as they were leaving. Client A calmed down and returned inside the home."</p> <p>The 6/30/15 BDDS report indicated on 6/29/15 at 3:30 PM "[Client B] walked out the back door and staff followed to keep him in sight. Staff sat down next to [client B] and [client B] grabbed at staff's clothing. Staff blocked and [client B] continued to grab at staff. Another staff member came out to assist and verbal (sic) redirected [client B] who then became physically aggressive towards that staff member. Staff member placed [client B] into a one person YSIS hold [(one person standing restraint)] for less than a minute by standing next to [client</p>			

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	<p>B] and placed one hand on his wrist to prevent him from punching. [Client B] calmed and hold was released. [Client B] apologized and had no further incidents."</p> <p>The 7/6/15 IAR indicated at 7 PM client A ran out the front door to the back yard wooded area in sight of staff. Client A was directed back into the house and he sat down on the couch. Client A then tried to run out the back door. The staff talked to client A and calmed him down.</p> <p>The 7/7/15 IAR indicated at 5 PM client A heard thunder and ran out of the house into the front yard and stood in the rain. The report indicated the staff directed client A to come back into the house and client A ran into the house, slipped and fell and obtained red marks on his right elbow and left knee.</p> <p>The 7/15/15 IAR indicated at 6:08 PM client A "eloped out the front door as staff was leaving." The report indicated client A headed to the back of the house around the garage and staff followed him trying to redirect him. Client A slipped on the wet grass and fell. Client A returned to the inside of the house.</p> <p>The 7/15/15 IAR indicated at 7:20 PM client A was yelling he wanted his mother and that he wanted to die. Client</p>			

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	<p>A started cursing at his house mates and the staff saying "Die, die. I want to die." Client A ran out of the front door and down the street toward a major highway. The staff ran after client A and grabbed client A by the shirt to stop him from running into oncoming traffic.</p> <p>The 7/17/15 BDDS report indicated on 7/16/15 at 6:23 PM "[Client B] was in the kitchen and a staff came into work. [Client B] went out the front door and slammed it. [Client B] started to run, yelling at staff to go home. Staff caught up to him and attempted to verbally redirect him to the house. [Client B] fell in the ditch beside the road and scraped his right cheek and a scrape on right knee. [Client B] went back to the house with staff with no further incidents."</p> <p>The 7/24/15 BDDS report indicated on 7/24/15 at 4:30 AM (sic - PM) "[Client A] ran around the car and kept running towards highway [name of highway]. Staff was running after and two cars had turned off of [name of highway] onto [name of road of group home] road. [Client A] was running down the road on the same side as the car and did not stop even though he could see the cars coming at him. The cars stopped and staff was able to catch up to [client A] before he reached highway [name of highway] by</p>			

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	<p>grabbing a hold of his hoodie (a sweatshirt). [Client A] stopped and staff immediately let go and walked back to the house with [client A]. Once back in the house [client A] became verbally aggressive toward staff and physically aggressive, attempting to punch staff. Staff blocked and [client A] started to fall backwards after swinging. Staff reached out to help prevent [client A] from falling by taking ahold (sic) of his shirt which ripped, but [client A] did not fall. Staff immediately let go and [client A] grabbed a chair throwing it at staff that blocked. Staff continued to offer coping mechanisms and [client A] went to his room where he calmed with no further incidents."</p> <p>__The report indicated "Plan to Resolve (Immediate and Long Term). No one was injured during the incident. [Client A] has a history of running when upset. [Client A] was within line of sight of staff. One staff was gone in the van with another client. One staff was on the front porch with two clients. The third staff was sitting at the dining room table with [client A]."</p> <p>The 8/2/15 BDDS report indicated on 8/2/15 at 5:35 PM "[Client B] ran out the back door. He (client B) came back inside and appeared to have calmed down. He ran a second time towards the</p>			

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	<p>back gate when he fell on the step, landing on his right knee and right hand. He calmed down and came back inside the house."</p> <p>The 8/13/15 BDDS report indicated on 8/13/15 at 10:30 AM "[Client B] returned from a doctor's appointment and told staff that he was going to run. Staff followed [client B] out the front door and where (sic) able to verbally redirect him back to the house. Once back in the house [client B] became physically aggressive and attempted to punch staff. [Client B] also attempted to kick and throw objects at staff. Staff was able to block. [Client B] apologized to staff and said that he was going to his room to calm down. Near his room he grabbed a card table and flipped it and said he was going to run. [Client B] then went out the back door and slammed it shut holding it closed. Staff went out the other door and [client B] swung at staff missing. [Client B] pushed staff attempting to go out the back gate. Staff attempted to redirect and [client B] grabbed the staff, throwing her and ripping her clothes. [Client B] then sat down in the grass. [Client B] calmed and had no further behaviors."</p> <p>The 8/15/15 IAR indicated at 11:20 AM "[Client B] was sitting on the front porch upset. He (client B) got more aggitated</p>			

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	<p>(sic) and ran out of the yard up the street into a yard. Staff followed closely. He then attacked staff, punching in the stomach and throwing sticks at them. After thirty minutes staff got [client B] redirected back to the house. He was calm for five minutes, got up and ran out the back door trying to run out gate. Staff tried redirecting him. He attacked her and he scraped his left hand on the brick wall of house. He sat in yard for fifteen minutes then came in house and sat in his room."</p> <p>The 8/18/15 BDDS report indicated on 8/17/15 at 2 PM "[Client A] was in the kitchen with a staff member. Staff heard a loud sound and turned and noticed that [client A] had removed the pin from a fire extinguisher and squeezed the handle for a second. [Client A] let go and started saying it wasn't me. [Client A] assisted in cleaning up with no further incidents."</p> <p>The 8/19/15 BDDS report indicated on 8/18/15 at 6:55 PM "[Client A] went to the medication room and became loud and threatened staff. [Client A] then grabbed the phone and ran out of the house. [Client A] ran to the police station that is at the end of [name of street the Community Alternatives Adept home was on] and highway [name of highway]. [Client A] was in staff's line of site (sic)</p>			

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	<p>that was catching up to him. [Client A] was at the police station door knocking on the door. Staff verbally redirected [client A]. [Client A] told the janitor that answered the door that he wanted the police and that he wants to die. [Client A] calmed and walked back to the house with staff. [Client A] sat at dining room table and started to color with staff. [Client A] got mad and ran past the staff that was with him and out the front door again. Staff followed and [client A] was in staff's line of sight. [Client A] made it to the police station again. Staff caught up and [client A] was out of breath and said he (client A) was ready to go home. [Client A] walked back home with staff and became verbally aggressive. [Client A] then began to turn over chairs and attempting (sic) to hit staff. Staff blocked and offered [client A] his coping mechanisms. [Client A] went to his room and began to calm."</p> <p>The 8/24/15 IAR indicated at 6 AM client A was agitated and yelling at his house mates without reason and began "to get violent" with the staff. The staff asked him to go to his room to calm down and he tried to run toward the highway. Staff stayed with him and redirected him toward the house. The report indicated this happened twice and that client A had pulled the fire alarm</p>			

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	<p>three times. The report indicated client A finally calmed down around 11 AM.</p> <p>The 8/28/15 BDDS report indicated on 8/27/15 at 11:45 AM "[Client A] came out of the laundry room with a hat and scarf laughing. Staff laughed with him. [Client A] then went behind the staff sitting at the dining room table and put the scarf around staff's neck and started choking (the staff) while laughing. Staff blocked and acquired scarf explaining that what he did was not funny and could hurt someone. Staff was taking scarf to another room and client A came up behind staff and kicked him (the staff) between the legs in the groin area. Staff redirected [client A] to his room to help him calm down. Once in his room [client A] turned around and punched staff in the jaw. Staff blocked further attempt and another staff took over. [Client A] stayed in his room to calm and apologized to staff after he calmed."</p> <p>The 8/28/15 IAR indicated at 1:30 PM client A grabbed the phone and ran into the garage without turning on the lights. Client A ran into a shelf and cut his lip.</p> <p>The 8/29/15 BDDS report indicated on 8/28/15 at 4:25 PM "[Client A] went for a walk with staff. [Client A] saw some kids playing and he (client A) grabbed his</p>			

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	<p>groin area while saying 'sexy baby.' Staff verbally redirected [client A] and he ran away from staff down the road. A car stopped and [client A] flipped the people in the car off (holding up a middle finger) and then grabbed his (client A's) groin area again while saying 'call me.' [Client A] continued to run from staff flipping off cars as they (the cars) went by him. Staff was within [client A's] site (sic) attempting to catch up to him. [Client A] made it to the [name of the police department] police station. [Client A] told a police officer there to arrest the staff, that they were being mean to him. The officer offered to take [client A] home in the squad car. Once in the car [client A] flipped off staff and then flipped switches turning on the lights and grabbed the radio talking on it. The officer and staff verbally redirected [client A] who then told them (the staff and the police officer) that he wanted to die. [Client A] went into the house and was making threats to hit staff and housemates. Staff offered coping mechanisms and [client A] sat down to write a letter."</p> <p>Review of an 8/18/15 email message from the BS to the PC and QIDP on 9/4/15 at 9 AM indicated "The IR (Incident Report) says there were only two staff on duty? That is not enough</p>			

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	during waking hours for someone who can and does run. He (client A) has ADHD (Attention Deficit Hyperactivity Disorder). He does not stop. Staff did not follow the BSP. Med room was open/unlocked so he could walk in. After he ran out the door the first time, he was able to get out the door a second time. Who was supposed to be with him? Staff have to be within arms length of him when he is on the move. Staff did not follow the BSP. The police station is on [name of highway]. He got there twice. The staff was not within arms length and he could have ran (sic) into the street on either trip and been hit by a car and be dead. Saying that he was in line of sight did nothing but indicate the staff could see when he got hit by the cars. He got to the police station and talked to a janitor who I'm (the BS) sure will tell the police. And, since he's (client A) been there twice now, we should expect him to make regular visits since he is fixated on the police. While I don't believe the definition of what is reportable has changed per BDDS (any event characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual or death of an individual), it appears the general definition recognized by [name of facility] has as [client A] running to [name of highway] twice			

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	<p>without staff close by would certainly seem to have the potential to result in significant harm, injury or death."</p> <p>Review of an email dated 8/16/15 from the BS to the QIDP on 9/4/15 at 9 AM indicated: "Not sure if [name of staff] called you yet or not. Some things to think about:</p> <p>__1. Apparently when she (the staff) arrived for her shift today, [client A] was in possession of a walkie talkie, the phone and flashlight from the emergency food supply and had reportedly by 2 PM today drank (sic) all six of the sodas he brought. Per [name of staff], when they tried to get those items from him since he wasn't supposed to have them, he got upset with them and he's all jacked up on six pops. I (the BS) talked to him and he wanted me to call the police on them, then said he wanted to die, called himself a b---t h--e then yelled at [client D] who was yelling about something else. He said he didn't want to talk to me and gave the phone to [name of staff]. I know this is partly the 2nd shift vs (versus)1st shift thing that always goes on. However, if [name of staff] is accurate, right now we need everyone to focus all their energy on staying one step ahead of [client A]. Neither you (the QIDP) or I (the BS) can tell them or write everything in a plan for them to do. We have to have faith they</p>			

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	<p>have some common sense. Just like the road is not for play neither are the walkies or phone. Whatever other food/drink he brought needs to be put up out of his sight and his access is to be per the menu. He won't be happy but in five minutes if redirected and with someone there to stay with him, he will move on to the next topic.</p> <p>__2. I (the BS) was there until 8:50 PM last night. I spent the majority of that time sitting with him talking, watching TV (television) and coloring and talking and talking in his bedroom and the living room outside his room. Within 45 minutes after I left, they decided to go sit outside on the front porch (even though this was after his shower, it was dark outside and time to wind down per his sleep protocol). [Name of staff] turns her head and he bolts toward the road and falls. Just like with the electronics, not having him outside in dark when you know he is going to take off, falls within the expectation of common sense. I am mindful that this is everyone's first day and they are used to the other guys. We need them to now take what they have learned and start engaging their brain for the entire shift. If they are unsure, they need to call."</p> <p>Review of an Internet note from the BS to the QIDP dated 5/7/15 on 9/4/15 at 9</p>			

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	<p>AM indicated: "I'm (the BS) updating his (client A's) plan today to put a 30 day elopement protocol in place. He (client A) must be in line of sight at all times. His door is to remain open at all times unless there is a staff in his room with him - that includes bed time. We will re-evaluate in 30 days. That means staff must go and stay in his room with him if that door is shut. He will not like this but we have no other way right now to keep him safe since he knows how to turn off the alarms and can reach them. If [name of maintenance staff] can come up with some other method of alarms we can re-evaluate."</p> <p>Review of an email from the BS dated 10/15/14 on 9/4/15 at 9 AM indicated: "Staff have to move when [client A] moves. Every time. With three staff and four guys (clients), I know that leaves one of the guys free. It can't be [client A] If he isn't going out a door to run down the street or through the field or chasing would-be criminals out of the back yard through the gate, he is going out and getting into unlocked staff cars and taking whatever he can grab. Or, he is going in a room, taking something that isn't his and either hiding it or throwing it away.... He is accomplished at turning off the door and window alarms as well as checking the med door to see if it is</p>			

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	<p>locked. He is a really busy guy."</p> <p>1. Client A's record was reviewed on 9/3/15 at 11 AM. Client A's revised 4/23/15 Behavior Support Plan (BSP) indicated client A had targeted behaviors of physical aggression, verbal aggression, property disruption/destruction, leaving his assigned area (elopement), false allegations or mistreatment, stealing and socially inappropriate behaviors.</p> <p>The BSP indicated "[Client A] has a difficult time focusing for even short amounts of time and difficulty remaining still. He is almost always in motion in some way. [Client A] has a history of self-injurious behaviors, physical aggression, verbal aggression, property disruption/destruction, threats to harm others, elopement, false allegations and socially offensive behavior which he will demonstrate at home or in the community. As a result of these behavioral issues, [client A] has been relatively isolated from others and has not learned positive socialization and relationship skills. These behaviors include: yelling, crying, cursing, throwing objects [(rocks, hammers, etc.)], hitting, kicking, hitting his head or hand on objects [(walls, floors, doors, windows)], intentional incontinence, refusing to follow rules, disregarding others personal</p>			

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	<p>space, making sexually inappropriate comments or gestures [(pulls down pants and exposes self)], making threats to kill or harm someone [(usually his mother)] and describing how. [Client A] does not share attention with peers and will have an escalation in behaviors if he feels he is not receiving the attention from whom he wants to receive it. [Client A] will also manipulate those around him by antagonizing and intimidating peers by insinuating himself into their activities or events [(sit on floor to block door, pound on doors or windows when staff are paying attention to peers and not him)]. [Client A] lacks impulse control and does not appear to understand cause and effect and the consequence of his actions. He does not have a sense of limits and will attempt to use the entire bottle or container of anything he has in his hand. This includes food. He has a tendency to hoard items and limit others access to his room. He is at risk to harm himself and others in the kitchen and around appliances [(the stove, microwave, oven)], all sharps, chemicals, flammable devices or materials [(matches, lighters, gasoline)] and tools and is at risk of exploitation and victimization in the community. He does not demonstrate safe pedestrian skills and may run to the road or traffic. [Client A] will attempt to exit through a window or door and will follow</p>			

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	<p>staff exiting if not redirected. [Client A] wants immediate gratification and will respond negatively to hearing the word 'no.' He will pick up items that are not his and put them in his pocket or may pull items from the trash to drink if it is a soda bottle. He is influenced by crime shows and will threaten to shoot others and make gun/shooting gestures with his hand. He requires consistent oversight, repetition and redirection in a structured, supportive and encouraging environment."</p> <p>Client A's BSP indicated "Leaves assigned areas (out of bounds):            ___All staff on duty are to have access to charged walkie-talkies to use when [client A] exits the home and is out of bounds: any time [client A] leaves an assigned area including areas in the home or areas where the group is at [(defined as the staff that are with him on a community outing)] without staff acknowledgement. This includes climbing out his alarmed window as well as walking out of the house to the front yard, the back yard or the garage without staff acknowledgement as well as entering housemate's bedrooms without permission.            ___If the window alarm from [client A's] bedroom window sounds, one staff should go immediately to [client A's]</p>			

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	<p>room and a second staff should go immediately outside to client A's window. If [client A] is attempting to open and climb out of his bedroom window, the inside staff will verbally redirect [client A] to talk to staff and stay in his room. If this is not successful, staff will physically redirect [client A] from the window, release and block his access to the window and if he persists, utilize a one person hold to keep him from the window. The outdoor staff will pull the window shut and be prepared to block [client A's] exit and then return to [client A's] room to assist with the intervention as needed.</p> <p>__If [client A] attempts to exit the home through one of the exit doors that go to the street (front door or garage door) staff will attempt to block front and garage exits and physically redirect him from the door. If [client A] persists, staff will continue to block the door and verbally redirect [client A] to exit through the back door to the back yard.</p> <p>__If [client A] exits the back doors to the fenced back yard, one staff will remain outside in the yard with him to block him from climbing the fence and/or exiting through a gate and the other staff will be outside the fence blocking access through the gate.</p> <p>__If [client A] is outside the fence and attempts to leave the grounds walking,</p>			

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	<p>one staff will walk with [client A] and keep within arm's length of him (client A) at all times. The second staff will immediately notify the QIDP and follow the QIDP's instructions. Second staff will radio walking staff regarding instructions. Staff walking with [client A] will let him know that you are there to talk with him and help him problem solve what is upsetting him. Staff walking with [client A] will let him know that once he returns back to the home you and he will go in his room and will talk about what is upsetting him and help him come up with a solution. Once back at home and calm, talk with [client A] and help him problem-solve. Do not attempt to hurry [client A]. The more [client A] believes he is being hurried, the more he will resist. Be prepared to take your time.</p> <p>__If [client A] is running into the road [(name of road)]: Walking staff will insure [client A's] safety as well as his/her own safety by blocking him (client A) from approaching the road and going into oncoming traffic. Staff will implement You're Safe I'm Safe: Start with the least restrictive approach: physical redirect or escort, then one person YSIS. If he (client A) continues and becomes aggressive utilize the two person YSIS to ensure his safety. Be firm and direct asking [client A] to walk with you away from the road so that you and</p>			

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	<p>he can do (preferred activity).            ___If [client A] is running into the road [(major highway or high traffic road: U.S. [name of highway])]. One staff will Immediately call 911 and then notify QIDP and follow QIDP's instructions. Walking staff will insure [client A's] safety as well as his/her own safety by blocking him from approaching the road and going into oncoming traffic. Staff will implement You're Safe I'm Safe. Start with the least restrictive approach: physical redirect or escort, then one person YSIS. If he continues and becomes aggressive utilize the two person YSIS to ensure his safety prior to him getting to the road. Be firm and direct asking [client A] to walk with you away from the road so that you and he can do [(preferred activity)].</p> <p>___If [client A] is on the front or back porch. [Client A] must not be on the back (or front) porch without staff within arm's length of him. Direct [client A] to a chair positioned in a safe location on front porch and sit in a chair close to it. Do not rush [client A]. Be prepared to take the time to sit and talk or walk with him. Attempt to redirect him to preferred activities. If he makes an effort to go toward the fence, use YSIS to redirect him away from the fence while in the backyard. If he is able to make it to the fence and is able to climb the fence,</p>			

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	<p>remain in arms reach to prevent falling and prompt him to come down. Let him know that once he returns back to the home you and he will go in his room and will talk about what is upsetting him and help him come up with a solution.</p> <p>__If [client A] is in the garage. [Client A] is not to be in the garage without staff within arm's length of him. Let him know that once he returns back to the home you and he will go in his room and will talk about what is upsetting him and help him come up with a solution.</p> <p>__911 Emergency System may ONLY be used when individual behaviors jeopardize the safety and well-being of peers, community members and staff and ONLY when all Rescare-Indianapolis/ICF and Human Rights Committee approved de-escalation and redirection techniques have been utilized and exhausted. Clinical Supervisor/QIDP and Behaviorist are to be notified IMMEDIATELY once the call is placed. Upon arrival of emergency personnel, residential staff will intercede on behalf of the individual to coordinate police intervention, according to individual's current behavior status. If the individual is sitting or standing alone with no weapon, making no threats and causing no harm, staff must explain to emergency personnel the individual is not currently threatening and verbal</p>			

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	<p>intervention will be more beneficial than physical intervention."</p> <p>Client A's Modification of Individual's Rights (MOIR) last reviewed 7/15/15 indicated:</p> <p>___ Client A "demonstrated the lack of survival skills necessary to provide for client A's safety, welfare, security and health while in the community."</p> <p>___ Client A "will be supervised during activities outside of the home."</p> <p>___ "[Client A] will have an alarm placed on his bedroom window, his living room windows and his living room back door which will sound when opened."</p> <p>___ "[Client A] may become excited or agitated and attempt to leave the home via his bedroom/living room window or door. In the process of doing so, [client A] may injure himself exiting through the window. Should he succeed in getting out of the window/door safely, [client A] poses a significant safety risk to himself as he has a history of running into the street and/or down the street with no regard for traffic, refusing to move for on-coming traffic, saying he wants to get hit by a car and die necessitating he be physically removed from the road."</p> <p>Client A's Targeted Behaviors Data Sheet for 2015 indicated the following behaviors from January 2015 through</p>				

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	<p>August 2015:</p> <p>Physical aggression - 341 incidents. Verbal aggression - 1,211 incidents. Property disruption - 204 incidents. Leaving assigned area - 140 incidents. Socially offensive behavior - 1,190 incidents.</p> <p>2. Client B's record was reviewed on 9/3/15 at 11 AM. Client B's record indicated client B was admitted to the facility on 5/26/15 with targeted behaviors of physical aggression, verbal aggression, property disruption/destruction, leaving his assigned area, inappropriate touch and non compliance with program tasks.</p> <p>Client B's BSP dated 5/26/15 indicated "[Client B] has a history of physical and verbal aggression and obsessing over women. He will select specific female staff, try to touch them inappropriately and become jealous when others talk to them. [Client B] has a history of seizures which in 2014 typically occurred monthly at night. [Client B] succeeds best when he has routine and structure in his environment and receives individualized attention."</p> <p>Client B's BSP indicated the following reactive strategies when client B left his assigned area:</p>			

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	<p>__ "All staff on duty are to have a charged walkie-talkie on their person during the shift.</p> <p>__ Any time [client B] leaves a designated area without staff knowledge and permission including the home or areas the group [(defined as the staff that is with him on a community outing)] is at.</p> <p>__ If [client B] has left the house/grounds and is out of staff sight, immediately call 911.</p> <p>__ If staff observe [client B] attempting to leave, ask him to stay. Calmly prompt him to problem solve with you.</p> <p>__ If [client B] does as requested, briefly thank him and resume the ongoing activity with no further comment.</p> <p>__ If the window alarm from [client B's] bedroom window sounds, one staff will go immediately to [client B's] room and a second staff will go immediately outside to [client B's] window.</p> <p>__ If [client B] is attempting to open and climb out of his bedroom window, the inside staff will physically redirect him from the window, release and block his access to the window and if he persists, utilize a one person hold to keep him from the window. The outdoor staff will pull the window shut and be prepared to block [client B's] exit and then return to his room to assist with the intervention as needed.</p> <p>__ If [client B] attempts to exit the home</p>			

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	<p>through one of the exit doors that go to the street [(front door or garage door)] staff will attempt to block front and garage exits and physically redirect him from the door. If [client B] persists, staff will continue to block the door and verbally redirect [client B] to exit through the back door to the back yard.</p> <p>__ If [client B] exits the back doors to the back yard, one staff will remain outside in the yard with him to block him from climbing the fence and/or exiting through a gate and the other staff will be outside the fence blocking access through the gate.</p> <p>__ If [client B] is outside the fence and attempts to leave the grounds, staff will follow [client B] and initially keep a short distance between him and themselves (no more than 3 feet). Do not chase [client B], shadow him from behind and provide minimal attention. Immediately notify the QIDP and Behaviorist. Let the QIDP know what is going on and follow QIDP's instructions. Ask [client B] to stop walking and return home. At that first prompt, tell [client B] that once he returns back to the home you and he will talk about what is upsetting him and you'll help him come up with a solution.</p> <p>__ If [client B] doesn't stop, continue to follow, provide minimal attention/conversation by prompting to stop ([Client B], please stop and return</p>			

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	<p>home.') every 5 minutes until he returns home.</p> <p>__ When [client B] returns to the home and he is calm talk with him and help him problem solve.</p> <p>__ If the area [client B] is trying to go to poses a risk of harm to himself or others block [client B], redirect using YSIS physical redirection or escort. If he persists, use YSIS one or two person hold."</p> <p>Client B's MOIR dated 5/26/15 indicated:</p> <p>__ Client B demonstrated the lack of survival skills necessary to provide for client B's safety, welfare and health while in the community.</p> <p>__ "Community integration training will continue on an ongoing basis with emphasis on social boundaries and safety and the team will consider developing a formal objective in this area as other priority skills have been acquired."</p> <p>__ "[Client B] will become excited or agitated and attempt to leave the home via his bedroom window. In the process of doing so, [client B] may injure himself exiting through the window. Should he succeed in getting out of the window safely, [client B] poses a significant safety risk to himself and others as when agitated, he has a history of running into the street and/or down the street with no regard for traffic, refusing to move for</p>			

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	<p>on-coming traffic, requiring staff to block or physically remove him from the road."</p> <p>Client B's Targeted Behaviors Data Sheet for 2015 indicated the following behaviors from May 2015 through August 2015: Physical aggression - 69 incidents. Verbal aggression - 107 incidents. Property disruption - 32 incidents. Leaving assigned area - 22 incidents. Inappropriate touch - 55 incidents.</p> <p>3. Client C's record was reviewed on 9/3/15 at 3 PM. Client C's 12/11/14 BSP indicated client C had targeted behaviors of making paranoid statements, physical aggression, verbal aggression and non-compliance with health and safety issues.</p> <p>Client C's BSP indicated client C had a significant history of delusions and challenging behaviors. Prior to moving into the group home client C did not socialize. "[Client C] refuses to wash off/shower in the tub or shower area. He says that he cannot do so as there is something in the water pipes that will come out in the water and harm him. He will occasionally wash off using wash cloths at the sink or bathing wipes. Consequently, alternative methods of hygiene are attempted. [Client C] will</p>			

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	<p>also refuse to change clothes without multiple prompts and tends to wear multiple layers of clothing (T-shirt, sweatshirt, coat) no matter the season or temperature. He may have a particular clothing item which he does not want to take off/resists having it washed....</p> <p>[Client C] will often refuse to participate in home activities with peers and staff, preferring to sit and watch.... If asked to assist with household tasks, [client C ] will often tell staff 'No; that is staff's job.'</p> <p>Client C's Targeted Behaviors Data Sheet for 2015 indicated the following behaviors from January 2015 through August 2015:</p> <p>Paranoid statements - 387 incidents. Physical aggression - 2 incidents. Verbal aggression - 61 incidents. Property disruption - 4 incidents. Non-compliance with health and safety issues - 21 incidents.</p> <p>4. Client D's record was reviewed on 9/3/15 at 4 PM. Client D's BSP dated 12/11/14</p> <p>"[Client D] has a history of aggressive behavior towards others, destroying property, throwing rocks at cars, exposing himself, making sexually inappropriate gestures/statements, running into the street and running at cars.</p>				

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	<p>Client D's Targeted Behaviors Data Sheet for 2015 indicated the following behaviors from January 2015 through August 2015:</p> <p>Physical aggression - 110 incidents. Verbal aggression - 400 incidents. Property disruption - 159 incidents. Leaving assigned area - 6 incidents. Socially offensive behaviors - 101 incidents. Delusional perseveration - 283 incidents.</p> <p>During interview with staff #4 on 9/2/15 at 3:45 PM, staff #4: __ Stated, "There are three of us (staff) here usually and one of us has to watch [client A], one of us has to watch [client B] and one of us has to watch [client D]. __ Indicated clients A and B had behaviors of leaving the home unsupervised. __ Indicated it was hard for him to run after client A and stated, "He's slick." __ Stated, "At the bat of an eye he can slip out the door or all we have to do is turn around or take our eyes off him and he's out the door."</p> <p>During interview with staff #5 on 9/2/15 at 4 PM, staff #5: __ Indicated three staff worked the evening shift. __ Indicated one staff usually stayed with client A, one staff with client B and one</p>			
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	<p>staff with client D.</p> <p>__ Stated, "We could use more staff. With only three of us, it's hard to be there for everybody, especially [client C]."</p> <p>__ Stated client C didn't like to be "messed with" and would just stay by himself or in his room unless prompted by staff to talk and participate.</p> <p>__ Indicated because of all of the behaviors in the home the home should be staffed with at least four people at all times.</p> <p>During interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/3/15 at 1 PM, the QIDP:</p> <p>__ Indicated three direct care staff worked in the home with four clients (A, B, C and D)</p> <p>__ Indicated the clients in the home had multiple behaviors requiring restraints at times to control the behaviors.</p> <p>__ Indicated client A required the majority of the attention from staff because of his high volume of behaviors.</p> <p>__ Indicated one staff was to be with client A at all times.</p> <p>__ Indicated one staff was to be with client B at all times.</p> <p>__ Indicated one staff was to be with client D at all times.</p> <p>__ Indicated client C required prompting and supervision from staff to ensure client C would complete his ADLS</p>			

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W 0227 Bldg. 00	<p>(Adult Daily Living Skills).            ___ Indicated client C did not bathe, wash his hair or change his clothing on a regular basis.            ___ Stated, "[Client C] is a loner and prefers to be left alone."            ___ Indicated client C often got left out because of insufficient staff to provide client C the attention and program needs he should have.</p> <p>This federal tag relates to Complaint #IN00179008.</p> <p>9-3-3(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview and record review for 2 of 2 sampled clients (A and B), the clients' Individual Support Plans (ISPs) failed to address the clients' identified training need in regard to pedestrian safety skills.</p> <p>Findings include:</p>	W 0227	<p><b>CORRECTION:</b></p> <p><i>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment. Specifically, the interdisciplinary team will develop prioritized objectives for Client A and Client</i></p>	10/10/2015

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	<p>Observations were conducted at the group home on 9/2/15 between 3:30 PM and 5 PM.</p> <p>__ There were three direct care staff with four male clients (clients A, B, C and D).</p> <p>__ The group home was a single level home with four bedrooms, two and half baths, two living rooms/entertainment rooms, a medication room, a kitchen, a laundry room, a small office and an attached garage.</p> <p>__ The home was located on a side road and was 0.2 miles (352 yards) from a major busy highway.</p> <p>__ There were egress doors in the dining room (the front door), the small living room (the side door), the large living room (the back door) and the garage door. All egress doors had alarms on them.</p> <p>__ Client A was a young male that was loud, in constant motion, was fast on his feet and was invasive with his peers' and the staffs' personal space.</p> <p>__ Client B was a quiet older male that was short in stature, had a slight forward lean and ambulated at a moderate pace.</p> <p>During this observation period client A frequently would run from one part of the home to another while the staff supervising client A would be several feet behind client A and within a few feet of rounding a corner. For a few seconds</p>		<p>B to train them toward developing effective pedestrian safety skills. Through observation the team determined that this deficient practice did not affect additional clients.</p> <p><b>PERVENTION:</b></p> <p>The agency will retrain QIDP regarding the need to develop necessary supports and measureable objectives to support clients toward independence. Members of the Operations Team (including the Clinical Supervisor, Program Manager, Nurse Manager and Executive Director) will incorporate audits of support documents into visits to the facility twice weekly for the next 30 days and weekly visits for an additional 60 days to assure appropriate supports are included in each client's support plan. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Director of Operations/General Manager will determine the level of ongoing support needed at the facility.</p> <p><b>RESPONSIBLE PARTIES:</b></p>	

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	<p>client A would be out of eyesight for the staff, giving client A the opportunity to exit the home.</p> <p>The facility reportable and investigative records were reviewed on 9/2/15 at 1 PM.</p> <p>The 10/7/14 Bureau of Developmental Disabilities Services (BDDS) report indicated on 10/6/14 at 10:15 PM "[Client A] was sitting at the dining room table when he got up and ran out the front door. Staff followed and [client A] stopped at highway [name of highway]. Staff caught up and attempted to verbally redirect [client A] back to the house. [Client A] refused and for his (client A's) safety staff used YSIS (You're Safe I'm Safe - a physical hold used to control behavior) standing to his (client A's) side assiting (sic) him back to the house. Once back, [client A] went to bed without further incident."</p> <p>The 3/30/15 Incident/Accident Report (IAR) indicated at 6:33 PM "[Staff #3 and staff #1] were out front (of the house) with [client D]. [Client A] saw us, came outside with [staff #6]. We stood in doorway, [client A] took off running towards the stream. [Staff #1] went (sic) get him [client A], his leg hit a stick and caused a scrape.... Staff stated, [client A] said 'PoPo (the police)' and made his</p>		<p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>				

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	<p>hand like a gun and went towards the tree. Therefore this not (sic) an elopement attempt but [client A] playing around. The team will continue to follow his support plan and encourage [client A] to use the back yard instead of the front to avoid running towards the road."</p> <p>The 4/26/15 BDDS report indicated on 4/25/15 at 8 PM "[Client A] was sitting at the dining room table and started to cry and say he wanted mom. [Client A] then got up and ran out the door. Staff verbally redirected to come back inside and [client A] became physically aggressive swinging an object he had at staff. Staff was able to block. [Client A] was placed into a two person YSIS hold for safety where one staff was on each side (of client A). Client A spit at staff and attempted to bite.... [Client A] calmed after a couple of minutes and then the hold was released. [Client A] went inside without further incident."</p> <p>__The 4/25/15 IAR indicated it was 8 PM and client A was in his pajamas when he went outside and the temperature outside was 34 degrees Fahrenheit.</p> <p>The 5/5/15 BDDS report indicated on 5/4/15 at 4 PM "[Client A] came out of his bedroom pulling his pants and underwear down to his ankles. [Client A]</p>						

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	<p>started laughing and grabbed his private area and started running through the house asking everyone to look at his private area while attempting to run. Staff redirected [client A] that he was being inappropriate and to please pull his pants up. Before staff could reach [client A], he tripped over his pants and fell into his door frame. [Client A's] inner thigh had connected with the door frame and [client A] laid on the floor laughing. When the staff called the QIDP to inform him [client A] grabbed the phone from staff and ran out the front door. Staff followed and when they caught up to him he stopped running and returned to the house with staff."</p> <p>The 5/7/15 BDDS report indicated on 5/7/15 at 7:35 AM "[Client A] was in his bedroom on the phone talking and was upset asking to move out and for his mom. Staff heard a school bus honking and staff went outside and the bus driver thought one of the individuals was walking down the road. Staff saw [client A] walking towards highway [name of highway] and caught up with [client A] at the [name of police] station which is less than 100 yards from site (sic). [Client A] returned to the house without incident."</p> <p>The Elopement/Missing Person Investigation Summary dated 5/7/15</p>			

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	<p>indicated: Client A "must have slipped out the back door by his room (bedroom)." Client A was able to turn off the door alarm by himself. Client A was discovered walking on the street in front of the group home and was headed toward a busy highway. The staff realized the client was gone when they heard the bus driver honking the horn.</p> <p>The 5/7/15 Confidential Witness Statement Form (CWSF) from staff #3 indicated client A had asked to call the Behavior Clinician (BC) and had taken the phone to his bedroom. Staff #3 indicated he began preparing client A's record for an appointment. "A couple min (minutes) pas (sic) I (staff #3) heard bus driver out front honking. [Staff #7] and I (staff #3) went outside. Driver (bus driver) said, 'I think one of your guys got away.' I looked towards [name of highway] and observe (sic) [client A] walking toward police station and I took off on foot after him." The 5/7/15 CWSF from staff #7 indicated staff #3 chased after client A on foot and staff #7 got the keys and followed in the facility van.</p> <p>The 5/18/15 IAR indicated at 5:45 PM "[Client A] got mad because he said he</p>			

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	<p>wants to run outside. Started hitting elbow and hand on bedroom window repeatedly yelling, 'I want to run. I want to die'."</p> <p>The 5/19/15 IAR indicated at 3:13 PM "[Client A] followed the staff outside while staff went to get a sweater out of car. As we (staff and client A) were coming inside, he (client A) acted like the 'PoPo' and took off towards the creek. Staff ran after him, tried to stop him from running through the creek. He (client A) went knees first, no injury noted, he came inside and is ok, left knee is a little red."</p> <p>The 5/26/15 BDDS report indicated on 5/26/15 at 1:05 PM "[Client B] moved in at noon and was upset about moving. [Client B] walked out the front door a total of five times attempting to walk home. [Client B] was never out of staff site (sic). The fourth time he walked out [client B] tripped on the terrain of the side of the road and landed on his right knee. [Client B's] right knee was skinned one inch in diameter and bleed slightly. All times that [client B] walked out he came back with verbal redirection. [Client B] was physically aggressive on the time he fell attempting to punch staff, but no one was injured."</p> <p>The 5/27/15 BDDS report indicated on</p>			

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	<p>5/27/15 at 11 AM "[Client B] ran out the front door towards the road not leaving staff's line of sight. Staff caught up to [Client B] to verbally redirect him to the house and he became physically aggressive toward staff attempting to hit and kick. [Client B] was verbally aggressive saying 'I will kill you; I will slit your throat.' Staff was able to block and gave [client B] time to calm. [Client B] returned to the house and started throwing chairs at staff and making threats. Staff applied a two person YSIS hold for safety where one staff stood on each side of [client B] with one hand on his wrist and the other arm around his waist. The hold was released after two minutes the staff talked to [client B] and was calm without further incident."</p> <p>The 6/2/15 BDDS report indicated on 6/2/15 at 9 AM "[Client B] was resting in his room. Staff member went to move their car and noticed [client B] walking on the road and went to catch up to him. Staff alerted coworkers and another staff went to assist. [Client B] returned with staff and attempted to walk out the door. Staff blocked and [client B] became verbally aggressive threatening (sic) to stab and cut staff. [Client B] became physically aggressive attempting to hit and kick staff."</p>			

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	<p>The 6/16/15 IAR indicated at 6:10 AM client A "took off out the front door" toward the driveway while the 3rd shift staff was leaving. The staff tried to stop him but was unable to and client A "ran into a staff's truck." The staff caught him as he was falling and client A got up and chased the staff as they were leaving. Client A calmed down and returned inside the home."</p> <p>The 6/30/15 BDDS report indicated on 6/29/15 at 3:30 PM "[Client B] walked out the back door and staff followed to keep him in sight. Staff sat down next to [client B] and [client B] grabbed at staff's clothing. Staff blocked and [client B] continued to grab at staff. Another staff member came out to assist and verbal (sic) redirected [client B] who then became physically aggressive towards that staff member. Staff member placed [client B] into a one person YSIS hold [(one person standing restraint)] for less than a minute by standing next to [client B] and placed one hand on his wrist to prevent him from punching. [Client B] calmed and hold was released. [Client B] apologized and had no further incidents."</p> <p>The 7/6/15 IAR indicated at 7 PM client A ran out the front door to the back yard wooded area in sight of staff. Client A was directed back into the house and he</p>			

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	<p>sat down on the couch. Client A then tried to run out the back door. The staff talked to client A and calmed him down.</p> <p>The 7/7/15 IAR indicated at 5 PM client A heard thunder and ran out of the house into the front yard and stood in the rain. The report indicated the staff directed client A to come back into the house and client A ran into the house, slipped and fell and obtained red marks on his right elbow and left knee.</p> <p>The 7/15/15 IAR indicated at 6:08 PM client A "eloped out the front door as staff was leaving." The report indicated client A headed to the back of the house around the garage and staff followed him trying to redirect him. Client A slipped on the wet grass and fell. Client A returned to the inside of the house.</p> <p>The 7/15/15 IAR indicated at 7:20 PM client A was yelling he wanted his mother and that he wanted to die. Client A started cursing at his house mates and the staff saying "Die, die. I want to die." Client A ran out of the front door and down the street toward a major highway. The staff ran after client A and grabbed client A by the shirt to stop him from running into oncoming traffic.</p> <p>The 7/17/15 BDDS report indicated on</p>			

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	<p>7/16/15 at 6:23 PM "[Client B] was in the kitchen and a staff came into work. [Client B] went out the front door and slammed it. [Client B] started to run, yelling at staff to go home. Staff caught up to him and attempted to verbally redirect him to the house. [Client B] fell in the ditch beside the road and scraped his right cheek and a scrape on right knee. [Client B] went back to the house with staff with no further incidents."</p> <p>The 7/24/15 BDDS report indicated on 7/24/15 at 4:30 AM (sic - PM) "[Client A] ran around the car and kept running towards highway [name of highway]. Staff was running after and two cars had turned off of [name of highway] onto [name of road of group home] road. [Client A] was running down the road on the same side as the car and did not stop even though he could see the cars coming at him. The cars stopped and staff was able to catch up to [client A] before he reached highway [name of highway] by grabbing a hold of his hoodie (a sweatshirt). [Client A] stopped and staff immediately let go and walked back to the house with [client A]."</p> <p>The 8/2/15 BDDS report indicated on 8/2/15 at 5:35 PM "[Client B] ran out the back door. He (client B) came back inside and appeared to have calmed</p>			

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	<p>down. He ran a second time towards the back gate when he fell on the step, landing on his right knee and right hand. He calmed down and came back inside the house."</p> <p>The 8/13/15 BDDS report indicated on 8/13/15 at 10:30 AM "[Client B] returned from a doctor's appointment and told staff that he was going to run. Staff followed [client B] out the front door and where (sic) able to verbally redirect him back to the house. Once back in the house [client B] became physically aggressive and attempted to punch staff. [Client B] also attempted to kick and throw objects at staff. Staff was able to block. [Client B] apologized to staff and said that he was going to his room to calm down. Near his room he grabbed a card table and flipped it and said he was going to run. [Client B] then went out the back door and slammed it shut holding it closed. Staff went out the other door and [client B] swung at staff missing. [Client B] pushed staff attempting to go out the back gate. Staff attempted to redirect and [client B] grabbed the staff throwing her and ripping her clothes. [Client B] then sat down in the grass. [Client B] calmed and had no further behaviors."</p> <p>The 8/15/15 IAR indicated at 11:20 AM "[Client B] was sitting on the front porch</p>			

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	<p>upset. He (client B) got more aggitated (sic) and ran out of the yard up the street into a yard. Staff followed closely. He then attacked staff, punching in the stomach and throwing sticks at them. After thirty minutes staff got [client B] redirected back to the house. He was calm for five minutes, got up ran and out the back door trying to run out gate. Staff tried redirecting him. He attacked her and he scraped his left hand on the brick wall of house. He sat in yard for fifteen minutes then came in house and sat in his room."</p> <p>The 8/19/15 BDDS report indicated on 8/18/15 at 6:55 PM "[Client A] went to the medication room and became loud and threatened staff. [Client A] then grabbed the phone and ran out of the house. [Client A] ran to the police station that is at the end of [name of street the Community Alternatives Adept home was on] and highway [name of highway]. [Client A] was in staff's line of site (sic) that was catching up to him. [Client A] was at the police station door knocking on the door. Staff verbally redirected [client A]. [Client A] told the janitor that answered the door that he wanted the police and that he wants to die. [Client A] calmed and walked back to the house with staff. [Client A] sat at dining room table and started to color with staff.</p>			

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	<p>[Client A] got mad and ran past the staff that was with him and out the front door again. Staff followed and [client A] was in staff's line of sight. [Client A] made it to the police station again. Staff caught up and [client A] was out of breath and said he (client A) was ready to go home. [Client A] walked back home with staff and became verbally aggressive. [Client A] then began to turn over chairs and attempting (sic) to hit staff. Staff blocked and offered [client A] his coping mechanisms. [Client A] went to his room and began to calm."</p> <p>The 8/24/15 IAR indicated at 6 AM client A was agitated and yelling at his house mates without reason and began "to get violent" with the staff. The staff asked him to go to his room to calm down and he tried to run toward the highway. Staff stayed with him and redirected him toward the house. The report indicated this happened twice and that client A had pulled the fire alarm three times. The report indicated client A finally calmed down around 11 AM.</p> <p>The 8/28/15 IAR indicated at 1:30 PM client A grabbed the phone and ran into the garage without turning on the lights. Client A ran into a shelf and cut his lip.</p> <p>The 8/29/15 BDDS report indicated on</p>			

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	<p>8/28/15 at 4:25 PM "[Client A] went for a walk with staff. [Client A] saw some kids playing and he (client A) grabbed his groin area while saying 'sexy baby.' Staff verbally redirected [client A] and he ran away from staff down the road. A car stopped and [client A] flipped the people in the car off (holding up a middle finger) and then grabbed his (client A's) groin area again while saying 'call me.' [Client A] continued to run from staff flipping off cars as they (the cars) went by him. Staff was within [client A's] site (sic) attempting to catch up to him. [Client A] made it to the [name of the police department] police station. [Client A] told a police officer there to arrest the staff, that they were being mean to him. The officer offered to take [client A] home in the squad car. Once in the car [client A] flipped off staff and then flipped switches turning on the lights and grabbed the radio talking on it. The officer and staff verbally redirected [client A] who then told them (the staff and the police officer) that he wanted to die. [Client A] went into the house and was making threats to hit staff and housemates. Staff offered coping mechanisms and [client A] sat down to write a letter."</p> <p>1. Client A's record was reviewed on 9/3/15 at 11 AM. Client A's revised</p>			

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	<p>4/23/15 Behavior Support Plan (BSP) indicated client A had a target behavior of, not all inclusive, leaving his assigned area (elopement).</p> <p>Client A's BSP indicated a definition of leaving his assigned area/elopement to be "Any time [client A] leaves an assigned area including areas in the home or areas where the group is at [(defined as the staff that are with him on a community outing)] without staff acknowledgement. This includes climbing out his alarmed window as well as walking out of the house to the front yard, the back yard or the garage without staff acknowledgement as well as entering housemate's bedrooms without permission."</p> <p>Client A's Modification of Individual's Rights (MOIR) last reviewed 7/15/15 indicated:            ___ Client A demonstrated the lack of survival skills necessary to provide for client A's safety, welfare, security and health while in the community.            ___ "Community integration training will continue on an ongoing basis with emphasis on social boundaries and safety and the team will consider developing a formal objective in this area as other priority skills have been acquired."            ___ "[Client A] may become excited or</p>			

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	<p>agitated and attempt to leave the home via his bedroom/living room window or door. In the process of doing so, [client A] may injure himself exiting through the window. Should he succeed in getting out of the window/door safely, [client A] poses a significant safety risk to himself as he has a history of running into the street and/or down the street with no regard for traffic, refusing to move for on-coming traffic, saying he wants to get hit by a car and die necessitating he be physically removed from the road."</p> <p>Client A's Comprehensive Functional Assessment (CFA) dated 8/2014 indicated:            ___ Client A could not cross the street safely by himself.            ___ Client A shows no community safety awareness of dangers.            ___ Client A did not obey traffic signals and/or pedestrian cross/walk signals.            ___ Client A did not look both ways prior to crossing a street.</p> <p>Client A's ISP dated 8/14/15 indicated no training objectives to assist client A with pedestrian/community safety.</p> <p>2. Client B's record was reviewed on 9/3/15 at 1 PM. Client B's record indicated client B was admitted to the facility on 5/26/15. Client B's 5/26/15</p>			

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	<p>BSP indicated client B had a target behavior of, not all inclusive, leaving his assigned area. Client B's BSP indicated "Leaves Assigned Area: any time [client B] leaves a designated area without staff knowledge and permission including the home or area the group [(defined as the staff that is with him on a community outing)] is at."</p> <p>Client B's MOIR dated 5/26/15 indicated:          ___ Client B demonstrated the lack of survival skills necessary to provide for client B's safety, welfare and health while in the community.          ___ "Community integration training will continue on an ongoing basis with emphasis on social boundaries and safety and the team will consider developing a formal objective in this area as other priority skills have been acquired."          ___ "[Client B] will become excited or agitated and attempt to leave the home via his bedroom window. In the process of doing so, [client B] may injure himself exiting through the window. Should he succeed in getting out of the window safely, [client B] poses a significant safety risk to himself and others as when agitated, he has a history of running into the street and/or down the street with no regard for traffic, refusing to move for on-coming traffic, requiring staff to block or physically remove him from the road."</p>			
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W 0240  Bldg. 00	<p>Client B's CFA dated 5/26/15 indicated client B could not cross the street safely by himself.</p> <p>Client B's ISP dated 5/26/15 indicated no training objectives to assist client B with pedestrian/community safety.</p> <p>During interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/3/15 at 1 PM, the QIDP:            ___ Indicated clients A and B required staff supervision at all times while in the community.            ___ Indicated clients A and B could not cross the street safely by themselves.            ___ Indicated client A's and B's ISPs did not include training objectives in regard to pedestrian safety.</p> <p>This federal tag relates to Complaint #IN00179008.</p> <p>9-3-4(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p>			
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	<p>Based on observation, interview and record review for 2 of 2 sampled clients (A and B), the clients' Individual Support Plans (ISPs) failed to include:</p> <p>__ How the staff were to supervise/monitor clients A and B while inside the home.</p> <p>__ How the staff were to position themselves to prevent client A from exiting an egress door.</p> <p>__ How the staff were to supervise/monitor client A to ensure client A did not disarm and/or break the window/door alarms.</p> <p>__ How the staff were to monitor the alarms in the home to ensure the alarms were intact and functioning.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 9/2/15 between 3:30 PM and 5 PM.</p> <p>__ There were three direct care staff with four male clients (clients A, B, C and D).</p> <p>__ The group home was a single level home with four bedrooms, two and half baths, two living rooms/entertainment rooms, a medication room, a kitchen, a laundry room, a small office and an attached garage.</p> <p>__ The home was located on a side road and was 0.2 miles (352 yards) from a major busy highway.</p>	W 0240	<p><b>CORRECTION:</b></p> <p><i>The individual program plan must describe relevant interventions to support the individual toward independence. Specifically:</i></p> <p>Behavior Support Plans for Client A and Client B will be revised to include assigning one to one supervision duties to specific staff on the day and evening shifts to assure consistent application of enhanced supervision.</p> <p>All staff have been retrained by the Behavioral Clinician regarding the need to position themselves between client A and B and exits as well as to assure that Client A and Client B do not disable or alter the functioning of the exit alarms and to notify a supervisor of any attempts to do so.</p> <p>Malfunctioning alarms will be repaired and/or replaced. Additionally, window alarms will be installed wherever they are not already present in common areas of the home.</p>	10/10/2015	

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	<p>__The local police station was located on the same busy highway a few yards from the end of the road the group home was located on and was visible from the group home.</p> <p>__There were egress doors in the dining room (the front door), the small living room (the side door), the large living room (the back door) and the garage door. All egress doors had alarms on them.</p> <p>__The back door opened up to a small area that was surrounded by a privacy fence with a gate allowing access to the large back yard.</p> <p>__The alarm on the back door by the QIDP's office was broken and non functioning.</p> <p>__The alarms on each egress door had different sounds that were not ear piercing but sounded like door bells and at times were difficult to hear above the noise in the home.</p> <p>__Client A had two large windows in his room. No alarms were observed on the windows.</p> <p>__Client B had two windows in his room. One window had a functioning alarm and the other window had no alarm.</p> <p>__There were no functioning alarms on the dining room and living room windows.</p> <p>__Client A was a young male that was loud, was in constant motion, was fast on</p>		<p>Staff will perform and document function checks of all alarms no less than once each shift and more frequently as needed. These inspections will include: assuring each alarm is operational, assuring the alarms have a uniform alert signal that can be easily distinguished from other sounds in the home and are loud enough to be heard over the ambient level of noise throughout the house.</p> <p>Through observation the team determined that this deficient practice did not affect additional clients.</p> <p><b>PREVENTION:</b></p> <p>The QIDP has been retrained regarding the need to incorporate all relevant interventions into support plans based on ongoing assessment, review of incident and behavior documentation and interdisciplinary input. Members of the Operations Team and the QIDP will conduct observations during active treatment sessions no less than twice weekly for the next 30 days, and no less than weekly for an additional 60 Days. At the conclusion of this period of intensive administrative</p>	

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	<p>his feet and was invasive of his peers' and the staffs' personal space.</p> <p>__ Client B was a quiet older male that was short in stature, had a slight forward lean and ambulated at a moderate pace.</p> <p>At 3:30 PM:</p> <p>__ Client A escorted this surveyor around his home starting with his bedroom.</p> <p>__ Client A had two large windows in his bedroom.</p> <p>__ Client A walked to the garage and pointed out his desk and furniture that used to be in his room but was now broken.</p> <p>__ Client A pointed out alarms on the doors and the windows and indicated he could turn the alarms off, change the sounds and/or take them down.</p> <p>__ Client A walked to the main bathroom and pointed out how the toilet was not working properly. Client A put both arms around the toilet bowl and began shifting the toilet up and sideways from the base of the floor.</p> <p>__ Staff #5 indicated client A had broken the toilet and the staff were waiting for the repairman to fix it.</p> <p>__ Staff #5 stated the half bath was kept locked "in case he (client A) would break the other bathroom" and indicated the staff carried the key to the half bath.</p> <p>__ Staff #5 stated the home had another full bath but client A had "messed with</p>		<p>monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential</p>	

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	<p>the pipes under the sink and the pipes were leaking" and the pipes were in need of repair.</p> <p>__ Client A's behaviors began to escalate. Client A got louder and began cursing at the staff, telling the staff to "shut up" while darting in and around the staff and other clients that were nearby.</p> <p>__ The PC (Program Coordinator) that was sitting at the dining room table at the time stated to client A, "Now you know that's not nice. Why don't you go outside for a little while?"</p> <p>At 4:05 PM:</p> <p>__ Client A lunged toward the QIDP.</p> <p>__ Staff #5 suggested to client A that he go outside with staff #5 to play basketball or to sweep the sidewalk.</p> <p>__ Staff #5 and client A went outside to sweep the sidewalk.</p> <p>__ Staff #5 remained nearby client A throughout the observation.</p> <p>__ Staff #5 was not within arms reach of client #5 throughout the observation.</p> <p>__ During this observation period client A frequently would run from one part of the home to another while the staff supervising client A would be several feet behind client A and within a few feet of rounding a corner. For a few seconds client A would be out of eyesight for the staff, giving client A the opportunity to</p>		<p>Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Administrative support at the home will include direct face to face assessment of clients to compare observed behaviors and needs with current support documents and making recommendations for revisions as appropriate.</p> <p><b>RESPONSIBLE PARTIES:</b></p> <p>QIDP, Residential Manager, Team Leader, Health Services Team, Direct Support Staff, Operations Team</p>	

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	<p>exit the home.</p> <p>Observations were conducted at the group home on 9/3/15 between 4:30 PM and 5 PM.</p> <p>__ At 4:30 PM client A was in his bedroom and staff #8 stood outside of client A's bedroom door.</p> <p>__ At 4:40 PM client A ran out of his bedroom and into the dining room.</p> <p>__ Staff #8 walked slowly behind him and did not have client A in line of sight at all times.</p> <p>__ Client A began running in and around the dining room table, going in and out of the kitchen, in and around the other staff while making fun of staff, bumping into the staff and laughing about it.</p> <p>During this observation period:</p> <p>__ Client A was near the egress door in the dining room while two of the three staff were in the kitchen and staff #8 was standing near the kitchen door on the opposite side of the table and several feet away from client A.</p> <p>__ Staff #8 would not have been able to prevent client A from exiting the front door at that time if client A had decided to run.</p> <p>__ The staff did not stay within arms reach of client A during this observation period.</p> <p>__ The staff was not observed to position</p>			

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	<p>themselves between the egress doors and client A and/ client B.</p> <p>The facility reportable and investigative records were reviewed on 9/2/15 at 1 PM.</p> <p>The 10/7/14 Bureau of Developmental Disabilities Services (BDDS) report indicated on 10/6/14 at 10:15 PM "[Client A] was sitting at the dining room table when he got up and ran out the front door. Staff followed and [client A] stopped at highway [name of highway]. Staff caught up and attempted to verbally redirect [client A] back to the house. [Client A] refused and for his (client A's) safety staff used YSIS (You're Safe I'm Safe - a physical hold used to control behavior) standing to his (client A's) side assiting (sic) him back to the house. Once back, [client A] went to bed without further incident."</p> <p>The 3/30/15 Incident/Accident Report (IAR) indicated at 6:33 PM "[Staff #3 and staff #1] were out front (of the house) with [client D]. [Client A] saw us, came outside with [staff #6]. We stood in doorway, [client A] took off running towards the stream. [Staff #1] went to get him [client A], his leg hit a stick and caused a scrape.... Staff stated, [client A] said 'PoPo (the police)' and made his hand like a gun and went towards the</p>			

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	<p>tree. Therefore this not (sic) an elopement attempt but [client A] playing around. The team will continue to follow his support plan and encourage [client A] to use the back yard instead of the front to avoid running towards the road."</p> <p>The 4/26/15 BDDS report indicated on 4/25/15 at 8 PM "[Client A] was sitting at the dining room table and started to cry and say he wanted mom. [Client A] then got up and ran out the door. Staff verbally redirected to come back inside and [client A] became physically aggressive swinging an object he had at staff. Staff was able to block. [Client A] was placed into a two person YSIS hold for safety where one staff was on each side (of client A). Client A spit at staff and attempted to bite.... [Client A] calmed after a couple of minutes and then the hold was released. [Client A] went inside without further incident."            __The 4/25/15 IAR indicated it was 8 PM and client A was in his pajamas when he went outside and the temperature outside was 34 degrees Fahrenheit.</p> <p>The 5/5/15 BDDS report indicated on 5/4/15 at 4 PM "[Client A] came out of his bedroom pulling his pants and underwear down to his ankles. [Client A] started laughing and grabbed his private</p>			

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	<p>area and started running through the house asking everyone to look at his private area while attempting to run. Staff redirected [client A] that he was being inappropriate and to please pull his pants up. Before staff could reach [client A], he tripped over his pants and fell into his door frame. [Client A's] inner thigh had connected with the door frame and [client A] laid on the floor laughing. When the staff called the QIDP to inform him [client A] grabbed the phone from staff and ran out the front door. Staff followed and when they caught up to him he stopped running and returned to the house with staff."</p> <p>The 5/7/15 BDDS report indicated on 5/7/15 at 7:35 AM "[Client A] was in his bedroom on the phone talking and was upset asking to move out and for his mom. Staff heard a school bus honking and staff went outside and the bus driver thought one of the individuals was walking down the road. Staff saw [client A] walking towards highway [name of highway] and caught up with [client A] at the [name of police] station which is less than 100 yards from site (sic). [Client A] returned to the house without incident."</p> <p>The Elopement/Missing Person Investigation Summary dated 5/7/15 indicated:</p>			

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	<p>Client A "must have slipped out the back door by his room (bedroom)." Client A was able to turn off the door alarm by himself. Client A was discovered walking on the street in front of the group home and was headed toward a busy highway. The staff realized the client was gone when they heard the bus driver honking the horn.</p> <p>The 5/7/15 Confidential Witness Statement Form (CWSF) from staff #3 indicated client A had asked to call the Behavior Clinician (BC) and had taken the phone to his bedroom. Staff #3 indicated he began preparing client A's record for an appointment. "A couple min (minutes) pas (sic) I (staff #3) heard bus driver out front honking. [Staff #7] and I (staff #3) went outside. Driver (bus driver) said, 'I think one of your guys got away.' I looked towards [name of highway] and observe (sic) [client A] walking toward police station and I took off on foot after him." The 5/7/15 CWSF from staff #7 indicated staff #3 chased after client A on foot and staff #7 got the keys and followed in the facility van.</p> <p>The 5/19/15 IAR indicated at 3:13 PM "[Client A] followed the staff outside while staff went to get a sweater out of</p>			
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	<p>car. As we (staff and client A) were coming inside, he (client A) acted like the 'PoPo' and took off towards the creek. Staff ran after him, tried to stop him from running through the creek. He (client A) went knees first, no injury noted, he came inside and is ok, left knee is a little red."</p> <p>The 5/26/15 BDDS report indicated on 5/26/15 at 1:05 PM "[Client B] moved in at noon and was upset about moving. [Client B] walked out the front door a total of five times attempting to walk home. [Client B] was never out of staff site (sic). The fourth time he walked out [client B] tripped on the terrain of the side of the road and landed on his right knee. [Client B's] right knee was skinned one inch in diameter and bleed slightly. All times that [client B] walked out he came back with verbal redirection. [Client B] was physically aggressive on the time he fell attempting to punch staff, but no one was injured."</p> <p>The 5/27/15 BDDS report indicated on 5/27/15 at 11 AM "[Client B] ran out the front door towards the road not leaving staff's line of sight. Staff caught up to [Client B] to verbally redirect him to the house and he became physically aggressive toward staff attempting to hit and kick. [Client B] was verbally aggressive saying 'I will kill you; I will</p>			

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	<p>slit your throat.' Staff was able to block and gave [client B] time to calm. [Client B] returned to the house and started throwing chairs at staff and making threats. Staff applied a two person YSIS hold for safety where one staff stood on each side of [client B] with one hand on his wrist and the other arm around his waist. The hold was released after two minutes the staff talked to [client B] and was calm without further incident."</p> <p>The 6/2/15 BDDS report indicated on 6/2/15 at 9 AM "[Client B] was resting in his room. Staff member went to move their car and noticed [client B] walking on the road and went to catch up to him. Staff alerted coworkers and another staff went to assist. [Client B] returned with staff and attempted to walk out the door. Staff blocked and [client B] became verbally aggressive threatening (sic) to stab and cut staff. [Client B] became physically aggressive attempting to hit and kick staff. Staff where (sic) able to block. This lasted on and off for about an hour. Staff offered choices [(music, talking)] to help [client B] calm during the incident. [Client B] finally calmed and sat with staff and watched television."</p> <p>The 6/16/15 IAR indicated at 6:10 AM client A "took off out the front door"</p>			

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	<p>toward the driveway while the 3rd shift staff was leaving. The staff tried to stop him but was unable to and client A "ran into a staff's truck." The staff caught him as he was falling and client A got up and chased the staff as they were leaving. Client A calmed down and returned inside the home."</p> <p>The 6/30/15 BDDS report indicated on 6/29/15 at 3:30 PM "[Client B] walked out the back door and staff followed to keep him in sight. Staff sat down next to [client B] and [client B] grabbed at staff's clothing. Staff blocked and [client B] continued to grab at staff. Another staff member came out to assist and verbal (sic) redirected [client B] who then became physically aggressive towards that staff member. Staff member placed [client B] into a one person YSIS hold [(one person standing restraint)] for less than a minute by standing next to [client B] and placed one hand on his wrist to prevent him from punching. [Client B] calmed and hold was released. [Client B] apologized and had no further incidents."</p> <p>The 7/6/15 IAR indicated at 7 PM client A ran out the front door to the back yard wooded area in sight of staff. Client A was directed back into the house and he sat down on the couch. Client A then tried to run out the back door. The staff</p>			

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	<p>talked to client A and calmed him down.</p> <p>The 7/7/15 IAR indicated at 5 PM client A heard thunder and ran out of the house into the front yard and stood in the rain. The report indicated the staff directed client A to come back into the house and client A ran into the house, slipped and fell and obtained red marks on his right elbow and left knee.</p> <p>The 7/15/15 IAR indicated at 6:08 PM client A "eloped out the front door as staff was leaving." The report indicated client A headed to the back of the house around the garage and staff followed him trying to redirect him. Client A slipped on the wet grass and fell. Client A returned to the inside of the house.</p> <p>The 7/15/15 IAR indicated at 7:20 PM client A was yelling he wanted his mother and that he wanted to die. Client A started cursing at his house mates and the staff saying "Die, die. I want to die." Client A ran out of the front door and down the street toward a major highway. The staff ran after client A and grabbed client A by the shirt to stop him from running into oncoming traffic.</p> <p>The 7/17/15 BDDS report indicated on 7/16/15 at 6:23 PM "[Client B] was in the kitchen and a staff came into work.</p>			

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	<p>[Client B] went out the front door and slammed it. [Client B] started to run, yelling at staff to go home. Staff caught up to him and attempted to verbally redirect him to the house. [Client B] fell in the ditch beside the road and scraped his right cheek and a scrape on right knee. [Client B] went back to the house with staff with no further incidents."</p> <p>The 7/24/15 BDDS report indicated on 7/24/15 at 4:30 AM (sic - PM) "[Client A] ran around the car and kept running towards highway [name of highway]. Staff was running after and two cars had turned off of [name of highway] onto [name of road of group home] road. [Client A] was running down the road on the same side as the car and did not stop even though he could see the cars coming at him. The cars stopped and staff was able to catch up to [client A] before he reached highway [name of highway] by grabbing a hold of his hoodie (a sweatshirt). [Client A] stopped and staff immediately let go and walked back to the house with [client A]. Once back in the house [client A] became verbally aggressive toward staff and physically aggressive, attempting to punch staff. Staff blocked and [client A] started to fall backwards after swinging. Staff reached out to help prevent [client A] from falling by taking</p>			

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	<p>ahold (sic) of his shirt which ripped, but [client A] did not fall. Staff immediately let go and [client A] grabbed a chair throwing it at staff that blocked. Staff continued to offer coping mechanisms and [client A] went to his room where he calmed with no further incidents."</p> <p>The 8/2/15 BDDS report indicated on 8/2/15 at 5:35 PM "[Client B] ran out the back door. He (client B) came back inside and appeared to have calmed down. He ran a second time towards the back gate when he fell on the step, landing on his right knee and right hand. He calmed down and came back inside the house."</p> <p>The 8/13/15 BDDS report indicated on 8/13/15 at 10:30 AM "[Client B] returned from a doctor's appointment and told staff that he was going to run. Staff followed [client B] out the front door and where (sic) able to verbally redirect him back to the house. Once back in the house [client B] became physically aggressive and attempted to punch staff. [Client B] also attempted to kick and throw objects at staff. Staff was able to block. [Client B] apologized to staff and said that he was going to his room to calm down. Near his room he grabbed a card table and flipped it and said he was going to run. [Client B] then went out the</p>			

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	<p>back door and slammed it shut holding it closed. Staff went out the other door and [client B] swung at staff missing. [Client B] pushed staff attempting to go out the back gate. Staff attempted to redirect and [client B] grabbed the staff throwing her and ripping her clothes. [Client B] then sat down in the grass. [Client B] calmed and had no further behaviors."</p> <p>The 8/15/15 IAR indicated at 11:20 AM "[Client B] was sitting on the front porch upset. He (client B) got more aggitated (sic) and ran out of the yard up the street into a yard. Staff followed closely. He then attacked staff, punching in the stomach and throwing sticks at them. After thirty minutes staff got [client B] redirected back to the house. He was calm for five minutes, got up and ran out the back door trying to run out gate. Staff tried redirecting him. He attacked her and he scraped his left hand on the brick wall of house. He sat in yard for fifteen minutes then came in house and sat in his room."</p> <p>The 8/19/15 BDDS report indicated on 8/18/15 at 6:55 PM "[Client A] went to the medication room and became loud and threatened staff. [Client A] then grabbed the phone and ran out of the house. [Client A] ran to the police station that is at the end of [name of street the</p>						

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	<p>Community Alternatives Adept home was on] and highway [name of highway]. [Client A] was in staff's line of site (sic) that was catching up to him. [Client A] was at the police station door knocking on the door. Staff verbally redirected [client A]. [Client A] told the janitor that answered the door that he wanted the police and that he wants to die. [Client A] calmed and walked back to the house with staff. [Client A] sat at dining room table and started to color with staff. [Client A] got mad and ran past the staff that was with him and out the front door again. Staff followed and [client A] was in staff's line of sight. [Client A] made it to the police station again. Staff caught up and [client A] was out of breath and said he (client A) was ready to go home. [Client A] walked back home with staff and became verbally aggressive. [Client A] then began to turn over chairs and attempting (sic) to hit staff. Staff blocked and offered [client A] his coping mechanisms. [Client A] went to his room and began to calm."</p> <p>The 8/24/15 IAR indicated at 6 AM client A was agitated and yelling at his house mates without reason and began "to get violent" with the staff. The staff asked him to go to his room to calm down and he tried to run toward the highway. Staff stayed with him and</p>			
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	<p>redirected him toward the house. The report indicated this happened twice and that client A had pulled the fire alarm three times. The report indicated client A finally calmed down around 11 AM.</p> <p>The 8/28/15 BDDS report indicated on 8/27/15 at 11:45 AM "[Client A] came out of the laundry room with a hat and scarf laughing. Staff laughed with him. [Client A] then went behind the staff sitting at the dining room table and put the scarf around staff's neck and started choking (the staff) while laughing. Staff blocked and acquired scarf explaining that what he did was not funny and could hurt someone. Staff was taking scarf to another room and client A came up behind staff and kicked him (the staff) between the legs in the groin area. Staff redirected [client A] to his room to help him calm down. Once in his room [client A] turned around and punched staff in the jaw. Staff blocked further attempt and another staff took over. [Client A] stayed in his room to calm and apologized to staff after he calmed."</p> <p>The 8/28/15 IAR indicated at 1:30 PM client A grabbed the phone and ran into the garage without turning on the lights. Client A ran into a shelf and cut his lip.</p> <p>The 8/29/15 BDDS report indicated on</p>			

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	<p>8/28/15 at 4:25 PM "[Client A] went for a walk with staff. [Client A] saw some kids playing and he (client A) grabbed his groin area while saying 'sexy baby.' Staff verbally redirected [client A] and he ran away from staff down the road. A car stopped and [client A] flipped the people in the car off (holding up a middle finger) and then grabbed his (client A's) groin area again while saying 'call me.' [Client A] continued to run from staff flipping off cars as they (the cars) went by him. Staff was within [client A's] site (sic) attempting to catch up to him. [Client A] made it to the [name of the police department] police station. [Client A] told a police officer there to arrest the staff, that they were being mean to him. The officer offered to take [client A] home in the squad car. Once in the car [client A] flipped off staff and then flipped switches turning on the lights and grabbed the radio talking on it. The officer and staff verbally redirected [client A] who then told them (the staff and the police officer) that he wanted to die. [Client A] went into the house and was making threats to hit staff and housemates. Staff offered coping mechanisms and [client A] sat down to write a letter</p> <p>1. Client A's record was reviewed on 9/3/15 at 11 AM.</p>			

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	<p>Client A's revised 4/23/15 Behavior Support Plan (BSP) indicated client A had a target behavior of, not all inclusive, leaving his assigned area (elopement).</p> <p>Client A's BSP indicated a definition of leaving his assigned area/elopement to be "Any time [client A] leaves an assigned area including areas in the home or areas where the group is at [(defined as the staff that are with him on a community outing)] without staff acknowledgement. This includes climbing out his alarmed window as well as walking out of the house to the front yard, the back yard or the garage without staff acknowledgement as well as entering housemate's bedrooms without permission."</p> <p>Client A's BSP indicated "Leaves assigned areas (out of bounds): __All staff on duty are to have access to charged walkie-talkies to use when [client A] exits the home and is out of bounds: any time [client A] leaves an assigned area including areas in the home or areas where the group is at [(defined as the staff that are with him on a community outing)] without staff acknowledgement. This includes climbing out his alarmed window as well as walking out of the house to the front</p>			
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	<p>yard, the back yard or the garage without staff acknowledgement as well as entering housemate's bedrooms without permission.</p> <p>__ If [client A] attempts to exit the home through one of the exit doors that go to the street (front door or garage door) staff will attempt to block front and garage exits and physically redirect him from the door. If [client A] persists, staff will continue to block the door and verbally redirect [client A] to exit through the back door to the back yard.</p> <p>__ If [client A] exits the back doors to the fenced back yard, one staff will remain outside in the yard with him to block him from climbing the fence and/or exiting through a gate and the other staff will be outside the fence blocking access through the gate.</p> <p>__ If [client A] is in the garage. [Client A] is not to be in the garage without staff within arm's length of him. Let him know that once he returns back to the home you and he will go in his room and will talk about what is upsetting him and help him come up with a solution.</p> <p>Client A's Modification of Individual's Rights (MOIR) last reviewed 7/15/15 indicated: __ Client A "demonstrated a lack of survival skills necessary to provide for client A's "safety, welfare, security and</p>			

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	<p>health while in the community."            __ Client A "will be supervised during activities outside of the home."            __ "[Client A] will have an alarm placed on his bedroom window, his living room windows and his living room back door which will sound when opened."            __ "[Client A] may become excited or agitated and attempt to leave the home via his bedroom/living room window or door. In the process of doing so, [client A] may injure himself exiting through the window. Should he succeed in getting out of the window/door safely, [client A] poses a significant safety risk to himself as he has a history of running into the street and/or down the street with no regard for traffic, refusing to move for on-coming traffic, saying he wants to get hit by a car and die necessitating he be physically removed from the road."</p> <p>Client A's ISP dated 8/14/15 failed to indicate how the staff were to supervise client A while inside the home to ensure client A's safety from elopement and failed to indicate how the staff were to block client A from an exit if the staff were behind the client.</p> <p>Client A's ISP failed to indicate how the door and the window alarms were to be monitored to ensure the alarms were working properly and had not been</p>			

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	<p>disarmed by client A.</p> <p>2. Client B's record was reviewed on 9/3/15 at 1 PM. Client B's record indicated client B was admitted to the facility on 5/26/15.</p> <p>Client B's 5/26/15 BSP indicated client B had a target behavior of, not all inclusive, leaving his assigned area.</p> <p>Client B's BSP indicated "Leaves Assigned Area: any time [client B] leaves a designated area without staff knowledge and permission including the home or area the group [(defined as the staff that is with him on a community outing)] is at."</p> <p>Client B's BSP indicated the following reactive strategies when client B left his assigned area:            __ If staff observe [client B] attempting to leave, ask him to stay. Calmly prompt him to problem solve with you.            __ If [client B] attempts to exit the home through one of the exit doors that go to the street [(front door or garage door)] staff will attempt to block front and garage exits and physically redirect him from the door. If [client B] persists, staff will continue to block the door and verbally redirect [client B] to exit through the back door to the back yard.</p>			

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	<p>__ If [client B] exits the back doors to the back yard, one staff will remain outside in the yard with him to block him from climbing the fence and/or exiting through a gate and the other staff will be outside the fence blocking access through the gate.</p> <p>Client B's MOIR dated 5/26/15 indicated: __ Client B demonstrated the lack of survival skills necessary to provide for client B's safety, welfare and health while in the community. __ Client B was to have an alarm on his bedroom window that would sound if the window was opened and alert staff that the window has been opened. __ "[Client B] will become excited or agitated and attempt to leave the home via his bedroom window. In the process of doing so, [client B] may injure himself exiting through the window. Should he succeed in getting out of the window safely, [client B] poses a significant safety risk to himself and others as when agitated, he has a history of running into the street and/or down the street with no regard for traffic, refusing to move for on-coming traffic, requiring staff to block or physically remove him from the road."</p> <p>Client B's 5/26/15 ISP failed to indicate how the staff were to supervise client B while inside the home to ensure client B's</p>			

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	<p>safety from elopement and failed to indicate how the staff were to block client B from an exit if the staff were behind the client.</p> <p>Client B's ISP failed to indicate how the door and window alarms were to be monitored to ensure the alarms were working properly and had not been disarmed by client A.</p> <p>During interview with staff #5 on 9/2/15 at 4 PM, staff #5:</p> <p>__ Indicated three staff work the evening shift and one staff had to stay near client A, one staff near client B and one staff near client D.</p> <p>__ Indicated clients A had a long history of leaving his assigned area.</p> <p>__ Indicated client B was new to the facility and also had behaviors of leaving his assigned area.</p> <p>__ Stated, "[Client A] usually takes off for [name of highway] when he leaves. The police station is there and he has gone there several times."</p> <p>__ Indicated client A was quick, a fast runner and would often run out of the house before the staff could block the exit door and/or stop client A from getting out the door.</p> <p>__ Indicated he was aware of the alarms on the doors but was not certain which windows if any had alarms on them.</p>			

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	<p>__When asked how do you know if the alarms are working and staff #5 stated, "They are always going off."</p> <p>During interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/3/15 at 1 PM, the QIDP:</p> <p>__ Stated client A "Typically runs toward (name of highway)."</p> <p>__ Indicated the highway client A chose to run toward was a major busy highway.</p> <p>__ Indicated client A has run in front of cars and cars have had to stop for client A on more than one occasion.</p> <p>__ Stated, "So far he hasn't gotten seriously hurt."</p> <p>__ Stated, "The staff should be within arms reach of him [client A] but he's (client A) just too fast . You've seen how fast he is."</p> <p>__ Indicated he did not know if client A's and B's ISP/BSP specified if client A and client B were to be within arms reach of the staff while inside the house or had to be within eyesight.</p> <p>__ Stated, "I usually have three staff and each one of them are with either [client A], [client B] or [client D]."</p> <p>__ When asked how the staff could block client A from an egress door if they were several feet behind client A and the QIDP stated, "Yeah, I see what you mean."</p> <p>__ Indicated clients A and B were to be within arms reach of staff whenever</p>			

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	<p>outside.</p> <p>__ Stated originally there were alarms on all of the windows and all of the doors in the home but client A was "quick and sneaky" and figured out how to disarm and/or remove the alarms.</p> <p>__ Indicated he did not know if the alarms were still on all of the windows without going around and physically checking each one.</p> <p>__ Indicated client A had attempted going out his window on a couple of occasions.</p> <p>__ Indicated there were alarms on all egress doors; the front door, both living room doors and the door going out to the garage.</p> <p>__ Stated, "We had to change out the alarms on the doors because [client A] figured out how to disarm the old ones."</p> <p>__ Stated, "With the ones that are on now we can set them to have different alarm sounds for each door, but he's figured out how to mess with that too."</p> <p>__ Indicated he (the QIDP) was not aware the door alarm on the back door by the QIDP's office was not functioning and was missing one piece of the alarm until pointed out by this surveyor.</p> <p>__ When asked how the window and door alarms were to be monitored to ensure the alarms were on the doors and windows and were working, the QIDP stated, "I didn't think about that. I guess I should put something in place to make sure</p>			
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	<p>they're (the alarms) working?"</p> <p>During interview with the Behavior Specialist (BS) on 9/3/15 at 1 PM, the BS:</p> <p>__ Indicated the staff were to follow the clients' BSPs.</p> <p>__ Indicated there were to be alarms on all egress doors and on clients A's, B's and D's windows.</p> <p>__ Indicated client A should be within arms reach of staff at all times inside and outside of the home.</p> <p>__ When asked how the staff were to block client A from an egress door if they were several feet behind client A and the BS stated, "The staff should be positioned between him and the door to the outside or the garage door."</p> <p>__ Indicated if a staff was behind client A and client A was headed for the door then another staff should go to the door he is headed toward and block it before he gets there.</p> <p>__ Stated, "But that is not always possible and then the staff are to follow the BSP depending on which door [client A] has exited through."</p> <p>This federal tag relates to Complaint #IN00179008.</p> <p>9-3-4(a)</p>			

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W 0249  Bldg. 00	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 1 additional client (client C), the facility failed to ensure client C was offered formal and informal training opportunities and/or choices of leisure activities when time permitted and to ensure the staff followed client A's BSP (Behavior Support Plan).</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 9/2/15 between 3:30 PM and 5 PM.</p> <p>__ There were three direct care staff in the home with four male clients (A, B, C and D).</p> <p>__ The group home was a single level home with four bedrooms, a dining room, two living/entertainment rooms and an attached garage.</p> <p>__ The home was located 0.2 miles (352</p>	W 0249	<p><b>CORRECTION:</b></p> <p><i>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Specifically:</i></p> <p>All direct support staff will be retrained and receive ongoing face to face coaching from supervisors regarding the need to provide Client C with consistent, aggressive and continuous active treatment including but not limited to meal preparation,</p>	10/10/2015

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	<p>yards) from a major highway.</p> <p>__ The back door opened onto a small patio/area with a tall privacy fence and a gate.</p> <p>__ There were alarmed egress doors in the dining room (the front door), the small living room (the side door), the large living room (the back door) and the garage door.</p> <p>__ Client A was a young male that was loud, was in constant motion, was fast on his feet and was invasive of his peers' and the staffs' personal space.</p> <p>__ Client B was a quiet older male that was short in stature, had a slight forward lean and ambulated at a moderate pace.</p> <p>__ Client C was an older tall average size male who wore baggy clothing and had a full scraggly beard and long thinning hair that stuck together in clumps and who kept mostly to himself.</p> <p>__ Client D was a tall, quiet and large active young male.</p> <p>At 3:30 PM:</p> <p>__ Client A escorted this surveyor around his home starting with his bedroom.</p> <p>__ Staff #5 walked near by client A throughout the home.</p> <p>__ Client A's bedroom had two large windows.</p> <p>__ Client A walked to the garage and pointed out his desk and furniture that used to be in his room but was now</p>		<p>family style dining, other domestic skills and meaningful leisure activities.</p> <p>Client A's behavior support plan will be modified to include assign specific staff to maintain responsibility for enhanced supervision and prevent elopement. All staff will be trained toward proper implementation of the modified plan.</p> <p>Additionally, the Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than four direct support staff on duty between 6:00 AM and 10:00 PM to assure sufficient staff are in place to provide continuous active treatment to all clients.</p> <p><b>PREVENTION:</b></p> <p>The QIDP will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to meal preparation, family style dining,</p>	

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	<p>broken. Staff #5 indicated it was no longer in the garage because client A had broken his desk and dresser.</p> <p>__ Client A pointed out alarms on the doors and the windows and indicated he could turn the alarms off, change the sounds and/or take the alarms down down.</p> <p>__ Client A walked to the main bathroom and pointed out how the toilet was not working properly. Client A put both arms around the toilet bowl and began shifting the toilet up and sideways from the base of the floor.</p> <p>__ Staff #5 indicated client A had broken the toilet and they were waiting for maintenance to fix it.</p> <p>__ Client A's behaviors began to escalate. Client A got louder and began cursing at the staff, telling the staff to "shut up" while darting in and around the staff and other clients that were nearby.</p> <p>__ At 4:05 PM, client A lunged toward the QIDP.</p> <p>__ Staff #5 suggested to client A that he go outside with staff #5 to play basketball or to sweep the sidewalk.</p> <p>__ Staff #5 and client A went outside.</p> <p>__ At 5 PM the clients prepared to sit down to eat their evening meal. Client A was darting in and around the table, pouring drinks when he was asked not to, switching the dinnerware around and was</p>		<p>other domestic skills and meaningful leisure activities and implementation of behavior supports. Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations during active treatment sessions no less than three times weekly for the next 30 days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Active Treatment sessions to be monitored are defined as:</p> <p>Mornings: Beginning at 6:30 AM and through morning transport and including the following: Medication administration, meal preparation and breakfast, morning hygiene and domestic skills training through transport to work and day service. Morning active treatment monitoring will include staff from both the day and overnight shifts.</p> <p>Evenings: Beginning at approximately 4:30 PM through</p>	

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	<p>telling the staff and his peers to "shut up."</p> <p>Throughout this observation period client C sat in the living room near the back door in a small straight chair watching television and occasionally getting up to go sit outside in the fenced in patio area. Client C did not talk and/or interact with those around him unless spoken to. The staff did not provide client C with any training objectives and/or choices of leisure activities during this observation period.</p> <p>Observations were conducted at the group home on 9/3/15 between 4:30 PM and 5 PM. During this observation period:</p> <p>__ There were three direct care staff and four clients, (clients A, B, C and D).</p> <p>__ One staff supervised/monitored client A.</p> <p>__ One staff supervised/monitored client B.</p> <p>__ One staff supervised/monitored client D.</p> <p>At 4:40 PM client A ran out of his bedroom and into the dining room.</p> <p>__ Staff #8 walked slowly behind him and did not have client A in line of sight at all times.</p> <p>__ Client A began running in and around the dining room table, going in and out of</p>		<p>the evening meal and including the following: domestic and hygiene skills training, leisure skills training, medication administration, meal preparation and dinner. Evening monitoring will also include unannounced spot checks later in the evening toward bed time.</p> <p>In addition to active treatment observations, Operations Team Members and/or the Residential Manager will perform spot checks at varied times on the overnight shift no less than twice monthly –more frequently if training issues or problems are discovered.</p> <p>The Executive Director and Director of Operations/Regional Manager (area manager) will review documentation of administrative level monitoring of the facility –making recommendations as appropriate. As stated above, the Executive Director will participate directly in administrative monitoring of the facility. Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities.</p>	

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	<p>the kitchen, in and around the other staff while making fun of staff, bumping into the staff and laughing.</p> <p>__ Client A was near the egress door in the dining room while two of the three staff were in the kitchen.</p> <p>__ Staff #8 was standing near the kitchen on the opposite side of the table several feet away from client A.</p> <p>__ Staff #8 would not be able to prevent client A from running out the front door at that time if client A had decided to leave.</p> <p>During both observation periods the staff did not stay within arms reach of client A. The staff was not observed to position themselves between the egress doors and client A.</p> <p>Review of an 8/18/15 email message from the BS (Behavior Specialist) to the PC (Program Coordinator) and QIDP (Qualified Intellectual Disabilities Professional) on 9/4/15 at 9 AM indicated "The IR (Incident Report) says there were only two staff on duty? That is not enough during waking hours for someone who can and does run. He (client A) has ADHD (Attention Deficit Hyperactivity Disorder). He does not stop. Staff did not follow the BSP. Med room was open/unlocked so he could walk in. After he ran out the door the first</p>		<p><b>RESPONSIBLE PARTIES:</b></p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	
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	<p>time, he was able to get out the door a second time. Who was supposed to be with him? Staff have to be within arms length of him when he is on the move. Staff did not follow the BSP. The police station is on [name of highway]. He got there twice. The staff was not within arms length and he could have ran into the street on either trip and been hit by a car and be dead. Saying that he was in line of sight did nothing but indicate the staff could see when he got hit by the cars. He got to the police station and talked to a janitor who I'm (the BS) sure will tell the police. And, since he's (client A) been there twice now, we should expect him to make regular visits since he is fixated on the police. While I don't believe the definition of what is reportable has changed per BDDS (any event characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual or death of an individual), it appears the general definition recognized by [name of facility] has as [client A] running to [name of highway] twice without staff close by would certainly seem to have the potential to result in significant harm, injury or death."</p> <p>1. Client A's record was reviewed on 9/3/15 at 11 AM.</p>			

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	<p>Client A's revised 4/23/15 Behavior Support Plan (BSP) indicated client A had targeted behaviors of physical aggression, verbal aggression, property disruption/destruction, leaving his assigned area (elopement), false allegations or mistreatment, stealing and socially inappropriate behaviors.</p> <p>Client A's BSP indicated a definition of leaving his assigned area/elopement to be "Any time [client A] leaves an assigned area including areas in the home or areas where the group is at [(defined as the staff that are with him on a community outing)] without staff acknowledgement. This includes climbing out his alarmed window as well as walking out of the house to the front yard, the back yard or the garage without staff acknowledgement as well as entering housemate's bedrooms without permission."</p> <p>Client A's BSP indicated "STAFF ACTIONS: REACTIVE PROCEDURES Do not give [client A] anything or promise him anything to get him to stop a targeted behavior. Always initiate least restrictive alternatives first. Verbally redirect, physically redirect, block and move are the initial YSIS personal safety techniques to be used. YSIS Advanced techniques, such as one or two person</p>			

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	<p>holds or lifts, are only to be used as a last resort when necessary to prevent imminent injury to [client A] or others and after initial personal safety techniques have been attempted and proven unsuccessful."</p> <p>Client A's BSP indicated "Leaves assigned areas (out of bounds):                      __All staff on duty are to have access to charged walkie-talkies to use when [client A] exits the home and is out of bounds: any time [client A] leaves an assigned area including areas in the home or areas where the group is at [(defined as the staff that are with him on a community outing)] without staff acknowledgement. This includes climbing out his alarmed window as well as walking out of the house to the front yard, the back yard or the garage without staff acknowledgement as well as entering housemate's bedrooms without permission.                      __If the window alarm from [client A's] bedroom window sounds, one staff should go immediately to [client A's] room and a second staff should go immediately outside to client A's window. If [client A] is attempting to open and climb out of his bedroom window, the inside staff will verbally redirect [client A] to talk to staff and stay in his room. If this is not successful, staff</p>			

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	<p>will physically redirect [client A] from the window, release and block his access to the window and if he persists, utilize a one person hold to keep him from the window. The outdoor staff will pull the window shut and be prepared to block [client A's] exit and then return to [client A's] room to assist with the intervention as needed.</p> <p>__If [client A] attempts to exit the home through one of the exit doors that go to the street (front door or garage door) staff will attempt to block front and garage exits and physically redirect him from the door. If [client A] persists, staff will continue to block the door and verbally redirect [client A] to exit through the back door to the back yard.</p> <p>__If [client A] exits the back doors to the fenced back yard, one staff will remain outside in the yard with him to block him from climbing the fence and/or exiting through a gate and the other staff will be outside the fence blocking access through the gate.</p> <p>__If [client A] is outside the fence and attempts to leave the grounds walking, one staff will walk with [client A] and keep within arm's length of him (client A) at all times. The second staff will immediately notify the QIDP and follow the QIDP's instructions. Second staff will radio walking staff regarding instructions. Staff walking with [client A] will let him</p>			

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	<p>know that you are there to talk with him and help him problem solve what is upsetting him. Staff walking with [client A] will let him know that once he returns back to the home you and he will go in his room and will talk about what is upsetting him and help him come up with a solution. Once back at home and calm, talk with [client A] and help him problem-solve. Do not attempt to hurry [client A]. The more [client A] believes he is being hurried, the more he will resist. Be prepared to take your time.</p> <p>__If [client A] is running into the road [(name of road)]: Walking staff will insure [client A's] safety as well as his/her own safety by blocking him (client A) from approaching the road and going into oncoming traffic. Staff will implement You're Safe I'm Safe: Start with the least restrictive approach: physical redirect or escort, then one person YSIS. If he (client A) continues and becomes aggressive utilize the two person YSIS to ensure his safety. Be firm and direct asking [client A] to walk with you away from the road so that you and he can do (preferred activity).</p> <p>__If [client A] is running into the road [(major highway or high traffic road: U.S.[name of highway])]. One staff will Immediately call 911 and then notify QIDP and follow QIDP's instructions. Walking staff will insure [client A's]</p>			

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	<p>safety as well as his/her own safety by blocking him from approaching the road and going into oncoming traffic. Staff will implement You're Safe I'm Safe. Start with the least restrictive approach: physical redirect or escort, then one person YSIS. If he continues and becomes aggressive utilize the two person YSIS to ensure his safety prior to him getting to the road. Be firm and direct asking [client A] to walk with you away from the road so that you and he can do [(preferred activity)].</p> <p>__If [client A] is on the front or back porch. [Client A] must not be on the back (or front) porch without staff within arm's length of him. Direct [client A] to a chair positioned in a safe location on front porch and sit in a chair close to it. Do not rush [client A]. Be prepared to take the time to sit and talk with him. Attempt to redirect him to preferred activities. If he makes an effort to go toward the fence, use YSIS to redirect him away from the fence while in the backyard. If he is able to make it to the fence and is able to climb the fence, remain in arms reach to prevent falling and prompt him to come down. Let him know that once he returns back to the home you and he will go in his room and will talk about what is upsetting him and help him come up with a solution.</p> <p>__If [client A] is in the garage. [Client A]</p>			

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	<p>is not to be in the garage without staff within arm's length of him. Let him know that once he returns back to the home you and he will go in his room and will talk about what is upsetting him and help him come up with a solution.</p> <p>__911 Emergency System may ONLY be used when individual behaviors jeopardize the safety and well-being of peers, community members and staff and ONLY when all Rescare-Indianapolis/ICF and Human Rights Committee approved de-escalation and redirection techniques have been utilized and exhausted. Clinical Supervisor/QIDP and Behaviorist are to be notified IMMEDIATELY once the call is placed. Upon arrival of emergency personnel, residential staff will intercede on behalf of the individual to coordinate police intervention, according to individual's current behavior status. If the individual is sitting or standing alone with no weapon, making no threats and causing no harm, staff must explain to emergency personnel the individual is not currently threatening and verbal intervention will be more beneficial than physical intervention."</p> <p>Client A's Modification of Individual's Rights (MOIR) last reviewed 7/15/15 indicated:</p>			

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	<p>__ Client A demonstrated the lack of survival skills necessary to provide for client A's safety, welfare, security and health while in the community."</p> <p>__ "Community integration training will continue on an ongoing basis with emphasis on social boundaries and safety and the team will consider developing a formal objective in this area as other priority skills have been acquired."</p> <p>__ Client A "will be supervised during activities outside of the home."</p> <p>__ "[Client A] will have an alarm placed on his bedroom window, his living room windows and his living room back door which will sound when opened."</p> <p>__ "[Client A] may become excited or agitated and attempt to leave the home via his bedroom/living room window or door. In the process of doing so, [client A] may injure himself exiting through the window. Should he succeed in getting out of the window/door safely, [client A] poses a significant safety risk to himself as he has a history of running into the street and/or down the street with no regard for traffic, refusing to move for on-coming traffic, saying he wants to get hit by a car and die necessitating he be physically removed from the road."</p> <p>2. Client C's record was reviewed on 9/3/15 at 4 PM.</p>			

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	<p>Client C's BSP dated 12/11/14 indicated "[Client C] has made gradual improvements in socialization and attending to his health. [Client C] continues to become verbally aggressive when staff try to help him clean himself or his room or when he is prompted to do so. He will sometimes complete a part of the task, depending on who is asking and how he is feeling. [Client C] refuses to wash off/shower in the tub or shower area. He says that he cannot do so as there is something in the water pipes that will come out in the water and harm him. He will occasionally wash off using wash cloths at the sink or bathing wipes. Consequently, alternative methods of hygiene are attempted. [Client C] will also refuse to change clothes without multiple prompts and tends to wear multiple layers of clothing (T-shirt, sweatshirt, coat) no matter the season or temperature. He may have a particular clothing item which he does not want to take off/resists having it washed.... [Client C] will often refuse to participate in home activities with peers and staff, preferring to sit and watch. [Client C] finds his housemates very entertaining and will often talk to them and laugh at their actions. If asked to assist with household tasks, [client C] will often tell staff no; 'That is staff's job'. Conversely, [client C] will sometimes choose to be</p>			

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	<p>helpful around the house and seek out the company of peers and staff to sit with and talk. [Client C's] targeted behaviors include making paranoid statements, physical aggression, property disruption/destruction, verbal aggression, non-compliance: health and safety."</p> <p>Client C's ISP (Individualized Support Plan) dated 12/12/14 indicated the following training objectives: To assist in cleaning his room. To complete his daily hygiene - to swab his mouth. To ask for assistance when needing anything from the kitchen. To wash his hands prior to taking his medications. To identify one of his medications. To sit down with staff and plan a community activity and the money he would need to complete the activity.</p> <p>During interview with staff #4 on 9/2/15 at 3:45 PM, staff #4: __ Stated, "There are three of us (staff) here usually and one of us has to watch [client A], one of us has to watch [client B] and one of us has to watch [client D]. __ Indicated it was hard for him (staff #4) to run after client A and stated, "He's slick." __ Stated, "At the bat of an eye he (client</p>			

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	<p>A) can slip out the door or all we have to do is turn around or take our eyes off him and he's out the door."            __ Indicated client A was to be in line of sight at all times.</p> <p>During interview with staff #5 on 9/2/15 at 4 PM, staff #5:            __ Indicated three staff worked the evening shift.            __ Indicated one staff usually stayed with client A, one staff with client B and one staff with client D.            __ Stated staff were to "stay right with him (client A)" because of his behaviors.</p> <p>During interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/3/15 at 1 PM, the QIDP:            __ Indicated three direct care staff worked in the home with four clients (A, B, C and D)            __ Indicated the clients in the home had multiple behaviors requiring restraints at times to control the behaviors.            __ Indicated client A required the majority of the attention from staff because of his high volume of behaviors.            __ Indicated one staff was to be with client A at all times.            __ Indicated client A was to be within arms reach of staff at all times.            __ Indicated client A was fast making it difficult for the staff to keep client A</p>			

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	<p>within arms reach at all times and for the staff to be able to block the egress doors before client A got to them.</p> <p>__ Indicated client C required prompting and supervision from staff to ensure client C would complete his ADLS (Adult Daily Living Skills).</p> <p>__ Indicated client C did not bathe, wash his hair or change his clothing on a regular basis.</p> <p>__ Stated, "[Client C] is a loner and prefers to be left alone."</p> <p>__ Indicated client C often got left out because of insufficient staff to provide client C the attention and program needs he should have.</p> <p>__ Indicated the staff were to offer client C training objectives and/or leisure activities when time allowed.</p> <p>This federal tag relates to complaint #IN00179008.</p> <p>9-3-4(a)</p>						
W 0263 Bldg. 00	<p>483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE</p> <p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal</p>						

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	<p>guardian.</p> <p>Based on interview and record review for 1 of 2 sampled clients with restrictive programs, the facility failed to obtain written informed consent for the restrictive program and interventions for client B.</p> <p>Findings include:</p> <p>Client B's record was reviewed on 9/3/15 at 1 PM. Client B's 8/26/15 physician's orders indicated client B received the following medications daily for behavior modification: Depakote ER 1000 mg (milligrams), Atarax 20 mg, Topamax 25 mg, Prozac 40 mg and Zyprexa 10 mg. Client B also received an injection every three weeks of Invega 234 mg. for behavior modification.</p> <p>Client B's BSP (Behavior Support Plan) dated 5/26/15 indicated client B had the following behaviors: physical and verbal aggression, property disruption/destruction, leaving his assigned area without supervision, inappropriate touching and non-compliance with program tasks. Client B's BSP included the use of YSIS (You're Safe I'm Safe) physical restraints as a reactive strategy for some of client B's behaviors as well as the use of door/window alarms and the restriction</p>	W 0263	<p><b>CORRECTION:</b></p> <p><i>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Specifically, written informed consent for restrictive programs will be obtained from Client A's guardians. A review of facility support documents and Human Rights Committee records indicated that this deficient practice did not affect any additional clients.</i></p> <p><b>PREVENTION:</b></p> <p>When guardians and healthcare representatives are unable to attend team meetings face to face, consent forms will be sent via postal mail for review and signature, along with a stamped envelope addressed to the facility. If consents are not returned to the facility in a timely manner via standard postal mail, the QIDP will send the forms to the appropriate legal representative via registered mail to assure the documents have been delivered and received. Members of the Operations Team (including the Clinical Supervisor,</p>	10/10/2015

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W 9999  Bldg. 00	<p>from sharps and chemicals.</p> <p>Client B's ISP (Individualized Support Plan) dated 5/26/15 indicated client B's aunt and uncle served as client B's legal representative. Client B's record indicated no documentation of written informed consent from client B's legal representatives for client B's restrictive plans.</p> <p>During interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/3/15 at 1 PM, the QIDP indicated he had not obtained written informed consent from client B's legal representative in regard to client B's restrictive program plans.</p> <p>This federal tag relates to complaint #IN00179008.</p> <p>9-3-4(a)</p> <p>State Findings</p>	W 9999	<p>Program Manager, Nurse Manager and Executive Director) will incorporate audits of support documents into visits to the facility twice weekly for the next 30 days and weekly visits for an additional 60 days to assure prior written informed consent has been obtained for all restrictive programs. At the conclusion of this period of enhanced administrative monitoring and support, the Executive Director and Director of Operations/General Manager will determine the level of ongoing support needed at the facility.</p> <p><b>RESPONSIBLE PARTIES:</b></p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p><b>CORRECTION:</b></p>	10/10/2015

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	<p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met.</p> <p>460 IAC 9-3-1 Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by division.</p> <p>"Incidents to be reported to Bureau of Quality Improvement Services (BQIS) include any event or occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual including but not limited to: 8. Elopement of an individual that results in evasion of required supervision as described in the (Individualized Support Plan) as necessary for the individual's health and welfare."</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 2 sampled clients (A), the facility failed to notify the Bureau of Developmental Disabilities Services (BDDS) within 24 hours in accordance with state law regarding an incident of</p>		<p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by division. "Incidents to be reported to Bureau of Quality Improvement Services (BQIS) include any event or occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual including but not limited to: 8. Elopement of an individual that results in evasion of required supervision as described in the (Individualized Support Plan) as necessary for the individual's health and welfare."</p> <p>Specifically for Client A, the QIDP who is responsible for reporting incidents to the Bureau of Developmental Disability Services will be retrained in current incident reporting criteria. A review of progress notes, behavior tracking and incident documentation confirmed that this deficient practice did not affect other clients.</p> <p><b>PREVENTION:</b></p>	

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	<p>elopement that compromised client A's health and welfare and resulted in the staff grabbing client A's clothing to prevent the client from stepping onto a busy street/highway in front of oncoming cars.</p> <p>Findings include:</p> <p>The facility reportable records were reviewed on 9/2/15 at 1 PM.</p> <p>The 7/15/15 IAR (Incident Accident Report) indicated at 7:20 PM client A was yelling he wanted his mother and that he wanted to die. Client A started cursing at his house mates and the staff saying "Die, die, I want to die." Client A ran out the front door of the house and down the street toward a major highway. The staff ran after client A and grabbed client A by the shirt to stop him from running into on coming traffic. The IAR indicated client A was not out of sight of staff and was directed back to the group home.</p> <p>Review of an 8/18/15 email message from the BS (Behavior Consultant) to the PC (Program Coordinator) and Qualified Intellectual Disabilities Professional (QIDP) on 9/4/15 at 9 AM indicated "The IR (Incident Report) says there were only two staff on duty? That is not enough</p>		<p>Supervisory staff will review all facility documentation to assure incidents are reported as required. Specifically, the QIDP will conduct daily reviews of progress notes and behavior support plan tracking as well as the staff communication log and report findings to the Operations Team, as appropriate. Internal and day service incident reports will be sent directly to the Clinical Supervisor and the Program Manager, who will in turn coordinate and follow-up with the facility QIDP to assure incidents are reported to state agencies as required. Members of the Operations Team, comprised of Clinical Supervisors, the Program Manager, Nurse Manager and Executive Director, and the QIDP will conduct observations and documentation reviews during active Treatment sessions and documentation reviews no less than twice weekly for the next 30 days, no less than weekly for an additional 60 days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. These administrative documentation reviews will focus on identifying potentially reportable incidents, providing opportunities for</p>		

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	<p>during waking hours for someone who can and does run. He (client A) has ADHD (Attention Deficit Hyperactivity Disorder). He does not stop. Staff did not follow the BSP. Med room was open/unlocked so he could walk in. After he ran out the door the first time, he was able to get out the door a second time. Who was supposed to be with him? Staff have to be within arms length of him when he is on the move. Staff did not follow the BSP. The police station is on [name of highway]. He got there twice. The staff was not within arms length and he could have ran into the street on either trip and been hit by a car and be dead. Saying that he was in line of sight did nothing but indicate the staff could see when he got hit by the cars. He got to the police station and talked to a janitor who I'm (the BS) sure will tell the police. And, since he's (client A) been there twice now, we should expect him to make regular visits since he is fixated on the police. While I don't believe the definition of what is reportable has changed per BDDS (any event characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual or death of an individual), it appears the general definition recognized by [name of facility] has as [client A] running to [name of highway] twice</p>		<p>training and on site coaching of direct support staff to assure all incidents are reported in a timely manner.</p> <p><b>RESPONSIBLE PARTIES:</b> QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

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	<p>without staff close by would certainly seem to have the potential to result in significant harm, injury or death."</p> <p>During interview with the Qualified Intellectual Disabilities Professional (QIDP) on 9/3/15 at 1 PM, the QIDP:            ___ Indicated no report had been filed with BDDS in regard to the IAR of 7/15/15 for client A.            ___ Indicated the facility only reported to BDDS if a client left the house and was out of line of sight of the staff.</p> <p>9-3-1(a)</p>				