

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 10/23/2015
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W 0000 Bldg. 00	<p>This visit was for a post certification revisit (PCR) to the investigation of complaint #IN00179008 completed on 9/10/15.</p> <p>Complaint #IN00179008: Not corrected.</p> <p>Dates of Survey: October 19, 20 and 23, 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 11/2/15.</p>	W 0000		
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</p>	W 0104	CORRECTION:	11/22/2015

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>(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 all allegations of abuse were thoroughly investigated for clients B and D, to ensure client A was provided training in regard to pedestrian safety skills and to ensure the clients' bathrooms were maintained, clean and free of odor.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 10/19/15 between 2 PM and 5 PM and on 10/20/15 between 11 AM to 11:15 AM.</p> <p>__ There were two bathrooms in the home utilized by clients A, B, C and D.</p> <p>__ Both bathrooms had a strong odor of urine.</p> <p>__ The bathroom floors were sticky and stained with a brown/rust colored substance around the toilets.</p> <p>__ The toilet paper holder was broken in the bathroom near the living room.</p> <p>During interview with staff #2 on 10/19/15 at 2:30 PM, staff #2:</p> <p>__ Stated client D "has poor aim."</p> <p>__ Indicated client D frequently missed the toilet and would urinate on the floor.</p> <p>__ Indicated the bathrooms were cleaned once a night by the night shift staff.</p>		<p><i>The facility must assure that each client eats in a manner consistent with his or her developmental level. Specifically, staff will be retrained regarding the need to assure all clients participate in all aspects of meal preparation to the extent of their capabilities. Additionally, the facility will modify the staffing matrix to assure that there are no less than two staff on duty at meal times.</i></p> <p>PREVENTION:</p> <p>The Residential Manager will be expected to observe no less than one morning and two evening active treatment session per week to assess direct support staff interaction with clients and to provide hands on coaching and training including but not limited to meal preparation and family style dining. The Team Lead (non-exempt Residential Manager) 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 and family style dining.</p>		

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	<p>__ Indicated the facility was not allowed to use bleach.</p> <p>__ Indicated another cleaner was used and stated, "But it doesn't cut the smell."</p> <p>During interview with staff #4 on 10/20/15 at 11:30 AM, staff #4:</p> <p>__ Stated, "It smells bad in their (client A's, B's, C's and D's) bathrooms."</p> <p>__ Indicated client D frequently missed the toilet and would urinate on the floor.</p> <p>__ Indicated the bathrooms were supposed to be cleaned once a night by the night shift staff.</p> <p>__ Indicated the facility was not allowed to use bleach and used a different cleaner.</p> <p>__ Indicated the floors were sticky.</p> <p>During interview with the Qualified Intellectual Disabilities Professional (QIDP) on 10/20/15 at 1 PM, the QIDP:</p> <p>__ Indicated the bathroom floors were to be cleaned nightly by the night shift staff.</p> <p>__ Stated, "They (the facility administrators) won't let us use bleach anymore."</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 B and D. Please see W149.</p>		<p>Members of the Operations Team and the QIDP will conduct observations during active treatment sessions no less than twice weekly for the next 21 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 skills training, medication administration, meal preparation and dinner. Evening monitoring</p>	

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	<p>3. 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 B and D. Please see W154.</p> <p>4. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure client A was provided pedestrian safety skills. Please see W227.</p> <p>This deficiency was cited on 9/10/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN00179008.</p> <p>9-3-1(a)</p>		<p>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 support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to meal preparation and family style dining.</p>	

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W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 4 sampled clients (A and B), the facility failed to implement its policy and procedures to ensure all allegations of abuse were thoroughly investigated for clients B and D.</p> <p>Findings include:</p> <p>The facility's policies and procedures were reviewed on 10/19/15 at 1 PM. The 9/14/07 facility policy entitled "Abuse, Neglect, Exploitation" indicated: "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>The facility failed to implement its policy and procedures to ensure thorough investigations were</p>	W 0149	<p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION:</p> <p><i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. 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 with all potential witnesses –all individuals and staff present at the facility at the time of the alleged incident and background witness interviews when appropriate.</i></p>	11/22/2015

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	<p>conducted in regard to allegations of abuse for clients B and D. Please see W154.</p> <p>This deficiency was cited on 9/10/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN00179008.</p> <p>9-3-2(a)</p>		<p>PREVENTION:</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 for which they are responsible, within the five business day timeframe. The QIDP will turn in copies of all interview transcripts along with the final investigation summary for review by a Clinical Supervisor. The Clinical Supervisor will review each investigation to ensure that they are thorough –meeting regulatory</p>	

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W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 2 of 2 allegations of abuse reviewed, the facility failed to ensure all allegations of abuse were thoroughly investigated for clients B and D.	W 0154	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. RESPONSIBLE PARTIES: QIDP, Behavioral Clinician, Direct Support Staff, Operations Team, Director of Operations/General Manager CORRECTION: <i>The facility must have evidence that all alleged violations are thoroughly investigated.</i>	11/22/2015

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	<p>Findings include:</p> <p>The facility reportable and investigative records were reviewed on 10/19/15 at 1 PM.</p> <p>The 9/22/15 Bureau of Developmental Disabilities Services (BDDS) report indicated on 9/22/15 at 1:57 PM client D was standing in front of the medication room talking to a staff member when client B yelled client D's name and pushed client D causing client D to lose his balance and fall to the floor. The facility records indicated an investigation was conducted. The investigative records indicated no other client interviews and/or staff interviews. The facility records did not indicate a thorough investigation was conducted.</p> <p>The 10/14/15 BDDS report indicated on 10/13/15 at 6 AM clients B and D were sitting at the dining room table when client B stood up and slapped client D in the face. The facility records indicated an investigation was conducted. The investigative records indicated no staff or client interviews and no staff or client statements. The facility records did not indicate a thorough investigation was conducted.</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 with all potential witnesses –all individuals and staff present at the facility at the time of the alleged incident and background witness interviews when appropriate.</p> <p>PREVENTION:</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</p>	

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	<p>During interview with the Qualified Intellectual Disabilities Professional (QIDP) on 10/19/15 at 1 PM, the QIDP: ___ Indicated all allegations of abuse were to be investigated. ___ Stated, "Looks like I need to retrain the staff again." ___ Indicated the investigations of the allegations of client to client abuse on 9/22/15 and 10/13/15 were not thorough investigations.</p> <p>This deficiency was cited on 9/10/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN00179008.</p> <p>9-3-2(a)</p>		<p>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 QIDP will turn in copies of all interview transcripts along with the final investigation summary for review by a Clinical Supervisor. 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>RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>		

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W 0227 Bldg. 00	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN</p> <p>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.</p> <p>Based on observation, interview and record review for 1 of 2 sampled clients (A), the client's Individual Support Plan (ISP) failed to address the client's identified training need in regard to pedestrian safety skills.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/19/15 between 2 PM and 5 PM.</p> <p>__ There were four direct care staff with four male clients (clients A, B, C and D) during this observation period.</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>__ The group home was a single level home that was located on a side road and was 0.2 miles (352 yards) from a major busy highway.</p> <p>__ The home had four egress doors: one in the dining room (the front door), one in the small living room (the side door), one in the large living room (the back door) and one in the garage. All egress</p>	W 0227	<p>CORRECTION:</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 B to train them toward developing effective pedestrian safety skills. The QIDP will provide the Clinical Supervisor with copies of Interdisciplinary Team notes and ISP revisions to demonstrate the new goal is in place. Through observation the team determined that this deficient practice did not affect additional clients.</i></p> <p>PERVENTION:</p> <p>The agency will retrain QIDP regarding the need to develop necessary supports and measureable objectives to support clients toward independence. The training will focus on the need to develop</p>	11/22/2015
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	<p>doors had alarms on them.</p> <p>The facility reportable and investigative records were reviewed on 10/19/15 at 1 PM.</p> <p>The 5/5/15 Bureau of Developmental Disabilities Services (BDDS) report indicated on 5/4/15 at 4 PM client A "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. [Client A] returned to the house without incident."</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</p>		<p>measurable, time limited objectives that address all priority needs and skill deficits. 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 21 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>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

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	<p>keys and followed in the facility van.</p> <p>The 5/19/15 Incident Accident Report (IAR) indicated at 3:13 PM "[Client A] followed the staff outside while staff went to get a sweater out of car. As the staff was coming back inside the home client A "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 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 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</p>			

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	<p>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 7/24/15 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 8/19/15 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</p>			

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	<p>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 three times. The report indicated client A finally calmed down around 11 AM.</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 staff, that they were being mean to him. The officer offered to</p>			

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	<p>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>Client A's record was reviewed on 10/20/15 at 11 AM. Client A's revised 10/10/15 Behavior Support Plan (BSP) indicated client A had a target behavior of 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."</p>				

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	<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 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>During interview with the Qualified Intellectual Disabilities Professional (QIDP) on 10/20/15 at 1 PM, the QIDP: __ Indicated client A required staff supervision at all times while in the community. __ Indicated client A could not cross the street safely independently. __ Indicated client A's ISP did not include a specific training objective in regard to pedestrian safety.</p> <p>This deficiency was cited on 9/10/15. The facility failed to implement a systemic plan of correction</p>			

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W 0249 Bldg. 00	<p>to prevent recurrence.</p> <p>This federal tag relates to complaint #IN00179008.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION 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 2 of 4 sampled clients, (A and B) the facility failed to ensure the staff followed the clients' Behavior Support Plans (BSPs).</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/20/15 between 2 PM and 5 PM.</p> <p>___ There were four staff and four clients.</p> <p>___ At 4:28 PM client B left the house with staff #1 to go for a walk. Within a few seconds client B and staff #1 returned to the group home. Staff #1 stated he had forgotten to get a walkie talkie. Staff #1 and client B again left the</p>			W 0249	<p>CORRECTION:</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</p>		11/22/2015

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	<p>home to go on a walk.</p> <p>__At 4:31 PM client A stated, "I want to go for a walk too." Client A quickly walked to the front door with staff #2 closely behind him. Both client A and staff #2 exited the home via the front door. Client A began running down the dirt lane beside the group home. Staff #2 ran to keep up with client A. Client A caught up with staff #1 and client B. Client B and staff #1 immediately turned around and began heading back to the group home. Client A and staff #2 began walking north at a fast pace and quickly were out of sight.</p> <p>__At 4:35 PM staff #3 was asked how many walkie talkies were utilized in the home. Staff #3 went into the office and found two walkie talkies in a small plastic tub on top of the filing cabinet. Staff #3 indicated she had a walkie and staff #1 had a walkie. Staff #3 was asked if staff were to carry a walkie talkie with them when taking client A on a walk outside of the home. Staff #3 stated, "Yes, he (staff #2) must have forgotten to pick one up." Staff #3 quickly left the house to find client A and staff #2 to give staff #2 a walkie talkie.</p> <p>1. Client A's record was reviewed on 10/20/15 at 11 AM. Client A's revised 10/10/15 BSP indicated client A had targeted behaviors of physical aggression,</p>		<p>supervisors regarding the need to provide Client A and Client B with consistent, aggressive and continuous active treatment including with a focus on proper implementation of behavior supports including but not limited to elopement protocols.</p> <p>PREVENTION:</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 appropriate 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 twice weekly for the next 21 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>verbal aggression, property disruption/destruction, leaving his assigned area (elopement), false allegations or mistreatment, stealing and socially misappropriate behaviors.</p> <p>Client A's BSP indicated: "STAFF ACTIONS: All staff will wear a charged and working walkie-talkie for the duration of their shift. This will occur on all shifts, no matter which individuals are in the home. The walkie-talkies are to be used by staff to immediately notify co-workers when assistance is needed as well as communicate individual/event status to co-workers without leaving the area they are in."</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</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 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>	

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	<p>permission."</p> <p>2. Client B's record was reviewed on 10/20/15 at 11:30 AM. Client B's revised 10/10/15 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 BSP indicated: "STAFF ACTIONS: All staff will wear a charged and working walkie-talkie for the duration of their shift. This will occur on all shifts, no matter which individuals are in the home. The walkie-talkies are to be used by staff to immediately notify co-workers when assistance is needed as well as communicate individual/event status to co-workers without leaving the area they are in."</p> <p>Client B'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 B] exits the home and is out of bounds: any time [client B] 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</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 with a focus on implementation of behavior supports.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

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W 9999 Bldg. 00	<p>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>During interview with the Clinical Supervisor (CS) on 10/20/15 at 4:45 PM, the CS:</p> <p>__ Indicated clients A and B had a history of leaving the home unsupervised.</p> <p>__ Indicated all staff were to have a walkie talkie on them at all times.</p> <p>__ Indicated the walkie talkies were to be used to communicate between staff when assistance was needed.</p> <p>This deficiency was cited on 9/10/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN00179008.</p> <p>9-3-4(a)</p>	W 9999	N/A	11/22/2015	