

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN 46219
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W000000	<p>This visit was for an extended annual recertification and state licensure survey.</p> <p>Dates of Survey: 9/16/14, 9/17/14, 9/18/14, 9/22/14 and 9/24/14.</p> <p>Facility Number: 001008 Provider Number: 15G494 AIMS Number: 100245080</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/1/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview for 3 of 4 sampled clients (#2, #3 and #4) plus 1 additional client (#7), the governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent client #1's assaulting and</p>	W000104	<p>CORRECTION:</p> <p><i>The Governing body must exercise general policy, budget and operating direction over the facility. Specifically, the governing body has provided direction and oversight to assure that:</i></p>	10/24/2014

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>intimidating behavior towards clients #2, #3, #4, and #7, to prevent clients #3 and #4's elopement behaviors, to provide documentation of investigations regarding 4 incidents of physical aggression regarding client #1 and an elopement incident and allegation of abuse/mistreatment regarding client #4 and to develop and implement corrective measures to prevent further incidents of client #1's physical aggression and intimidating behavior and clients #3 and #4's elopement behaviors.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent client #1's assaulting and intimidating behavior towards clients #2, #3, #4, and #7, to prevent clients #3 and #4's elopement behaviors, to provide documentation of investigations regarding 4 incidents of physical aggression regarding client #1 and an elopement incident and allegation of abuse/mistreatment regarding client #4 and to develop and implement corrective measures to prevent further incidents of client #1's physical aggression and intimidating behavior and clients #3 and #4's elopement behaviors. Please see</p>		<p>The Governing Body has directed the facility to work with the Bureau of Developmental Disability Services to obtain an Emergency Medicaid Waiver to provide Client #1 with a residential placement that more appropriately meets client #1's Developmental, social and behavioral needs. In the interim, BDDS has agreed to assist with finding temporary placement in a more secure residential facility.</p> <p>Specifically for Clients #3 and #4, the governing body is overseeing the interdisciplinary team's development of additional safeguards and procedures to address elopement behavior.</p> <p>The Residential Manager has been retrained on components of a thorough investigation, specifically that all potential witnesses must be interviewed and all relevant documents reviewed, as well as the need to reproduce copies of investigation reports to medical surveyors upon request.</p> <p>PERVENTION:</p>	

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	<p>W149.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility provided documentation of investigations regarding 4 separate incidents of physical aggression regarding client #1 and 1 allegation of abuse/mistreatment and elopement regarding client #4. Please see W154.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility developed and implemented corrective measures to prevent further incidents of client #1's physical aggression and intimidating behavior and clients #3 and #4's elopement behaviors. Please see W157.</p> <p>9-3-1(a)</p>		<p>The governing body will assist with screening referrals for admission to the facility to assure they possess similar developmental, social and behavioral needs to the other clients residing in the facility. Final approval for admission will be contingent on the ability to maintain safety and emotional stability at the facility.</p> <p>The QIDP will bring all relevant elements of the interdisciplinary team together after serious incidents including but not limited to physical aggression and intimidation and elopement to review current supports and to make adjustments and revisions as needed. The QIDP will turn in copies of post-incident interdisciplinary team meeting notes to the Program Manager and Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will meet weekly with the QIDP to review incidents which require interdisciplinary team action. When patterns of physical aggression and intimidation emerge, the Operations Team will assist the facility for assessing whether client(s) remain an appropriate fit for the facility and take action toward finding alternative placement when appropriate. When patterns of elopement or other safety</p>		

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W000122	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 3 of 4 sampled clients (#2, #3 and #4) plus 1 additional client (#7). The facility failed to implement its policy and procedures to prevent client #1's assaulting and intimidating behavior towards clients #2, #3, #4, and #7, to prevent clients #3 and #4's elopement	W000122	concerns emerge, the QIDP will work with the team to develop additional supports as needed The Residential Manager will turn in copies of completed investigations to the Clinical Supervisor responsible for Quality Assurance to allow for appropriate oversight and follow-up. The Clinical Supervisor will follow-up with the Residential Manager as needed but no less than weekly to review incident documentation and completed investigations to assure they have been completed thoroughly. RESPONSIBLE PARTIES: QIDP, Residential Manager, Operations Team CORRECTION: <i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically:</i> The facility is working with the	10/24/2014	

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	<p>behaviors, to provide documentation of investigations regarding 4 incidents of physical aggression regarding client #1 and an elopement incident and allegation of abuse/mistreatment regarding client #4 and to develop and implement corrective measures to prevent further incidents of client #1's physical aggression and intimidating behavior and clients #3 and #4's elopement behaviors.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The facility failed to implement its policy and procedures to prevent client #1's assaulting and intimidating behavior towards clients #2, #3, #4 and #7, to prevent clients #3 and #4's elopement behaviors, to provide documentation of investigations regarding 4 incidents of physical aggression regarding client #1 and an elopement incident and allegation of abuse/mistreatment regarding client #4 and to develop and implement corrective measures to prevent further incidents of client #1's physical aggression and intimidating behavior and clients #3 and #4's elopement behaviors. Please see W149. 2. The facility failed to provide documentation of investigations regarding 4 separate incidents of physical aggression regarding client #1 and 1 		<p>Bureau of Developmental Disability Services to obtain an Emergency Medicaid Waiver to provide Client #1 with a residential placement that more appropriately meets client #1's Developmental, social and behavioral needs. In the interim, BDDS has agreed to assist with finding temporary placement in a more secure residential facility.</p> <p>Specifically for Clients #3 and #4, the interdisciplinary team will develop additional safeguards and procedures to address elopement behavior.</p> <p>The Residential Manager has been retrained on components of a thorough investigation, specifically that all potential witnesses must be interviewed and all relevant documents reviewed, as well as the need to reproduce copies of investigation reports to medical surveyors upon request.</p> <p>PERVENTION:</p> <p>The governing body will assist with screening referrals for admission to the facility to assure they possess similar developmental, social and</p>	

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	<p>allegation of abuse/mistreatment and elopement regarding client #4. Please see W154.</p> <p>3. The facility failed to develop and implement corrective measures to prevent further incidents of client #1's physical aggression and intimidating behavior and clients #3 and #4's elopement behaviors. Please see W157.</p> <p>9-3-2(a)</p>		<p>behavioral needs to the other clients residing in the facility. Final approval for admission will be contingent on the ability to maintain safety and emotional stability at the facility.</p> <p>The QIDP will bring all relevant elements of the interdisciplinary team together after serious incidents including but not limited to physical aggression and intimidation and elopement to review current supports and to make adjustments and revisions as needed. The QIDP will turn in copies of post-incident interdisciplinary team meeting notes to the Program Manager and Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will meet weekly with the QIDP to review incidents which require interdisciplinary team action. When patterns of physical aggression and intimidation emerge, the Operations Team will assist the facility for assessing whether client(s) remain an appropriate fit for the facility and take action toward finding alternative placement when appropriate. When patterns of elopement or other safety concerns emerge, the QIDP will work with the team to develop additional supports as needed</p>		

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W000149	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 observation, record review and interview for 3 of 4 sampled clients (#2, #3 and #4) plus 1 additional client (#7), the facility failed to implement its policy and procedures to prevent client #1's assaulting and intimidating behavior towards clients #2, #3, #4, and #7, to prevent clients #3 and #4's elopement behaviors, to provide documentation of investigations regarding 4 incidents of physical aggression regarding client #1 and an elopement incident and allegation	W000149	The Residential Manager will turn in copies of completed investigations to the Clinical Supervisor responsible for Quality Assurance to allow for appropriate oversight and follow-up. The Clinical Supervisor will follow-up with the Residential Manager as needed but no less than weekly to review incident documentation and completed investigations to assure they have been completed thoroughly. RESPONSIBLE PARTIES: QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team CORRECTION: <i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically:</i> The facility is working with the Bureau of Developmental Disability Services to obtain an Emergency Medicaid Waiver to	10/24/2014

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	<p>of abuse/mistreatment regarding client #4 and to develop and implement corrective measures to prevent further incidents of client #1's physical aggression and intimidating behavior and clients #3 and #4's elopement behaviors.</p> <p>Findings include:</p> <p>1. The facility's BDDS (Bureau of Developmental Disabilities Services) reports, IRs (Incident Reports) and investigations were reviewed on 9/16/14 at 1:32 PM. The review indicated the following:</p> <p>-BDDS report dated 7/19/14 indicated on 7/18/14 "While staff assisted the clients with cooking breakfast, [client #1] grabbed a knife off the counter while in the kitchen and placed it to the throat of [FC (Former Client) #1]. Staff quickly intervened using verbal prompts asking [client #1] to put down the knife. [Client #1] quickly complied putting the knife back on the counter. The staff redirected [client #1] by asking him to please leave the kitchen area, [client #1] quickly complied. Staff then began to supply emotional support to [FC #1] asking him was he ok, he said yes (sic). There was no visible injuries (sic) as a result of this incident. When asking [client #1] to please explain his actions, he stated that</p>		<p>provide Client #1 with a residential placement that more appropriately meets client #1's Developmental, social and behavioral needs. In the interim, BDDS has agreed to assist with finding temporary placement in a more secure residential facility.</p> <p>Specifically for Clients #3 and #4, the interdisciplinary team will develop additional safeguards and procedures to address elopement behavior.</p> <p>The Residential Manager has been retrained on components of a thorough investigation, specifically that all potential witnesses must be interviewed and all relevant documents reviewed, as well as the need to reproduce copies of investigation reports to medical surveyors upon request.</p> <p>PERVENTION:</p> <p>The governing body will assist with screening referrals for admission to the facility to assure they possess similar developmental, social and behavioral needs to the other clients residing in the facility. Final approval for admission will be</p>	

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	<p>in the book that he had read back at his old placement "That's what all rivals do." The 7/19/14 BDDS report indicated, "[Client #1] does have a BSP (Behavior Support Plan) that does display (sic) physical and verbal aggression. [Client #1] has been transitioned into this home for 2 weeks. It is apparent that through guidance [client #1] will need to understand that he no longer resides in a locked facility. The team has expressed consequently that through monitoring of communication and the importance of active listening this may be (sic) the important steps in building positive relationships with his housemates. Staff will continue to follow [client #1's] BSP. The staff will also continue to be alert and aware preventing any pre behavior situations that may occur."</p> <p>The review did not indicate documentation of an investigation regarding the 7/18/14 incident of client #1's attempted assault of FC #1.</p> <p>-BDDS report dated 7/28/14 indicated on 7/27/14 "A housemate, [client #1], was in [FC #1's] bedroom visiting. Without apparent antecedent, [client #1], kicked a (sic) [FC #1] in the nose. [FC #1] ran out of the room and called 911. Police arrived and arrested [client #1] and [FC #1] was transported to the [hospital]</p>		<p>contingent on the ability to maintain safety and emotional stability at the facility.</p> <p>The QIDP will bring all relevant elements of the interdisciplinary team together after serious incidents including but not limited to physical aggression and intimidation and elopement to review current supports and to make adjustments and revisions as needed. The QIDP will turn in copies of post-incident interdisciplinary team meeting notes to the Program Manager and Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will meet weekly with the QIDP to review incidents which require interdisciplinary team action. When patterns of physical aggression and intimidation emerge, the Operations Team will assist the facility for assessing whether client(s) remain an appropriate fit for the facility and take action toward finding alternative placement when appropriate. When patterns of elopement or other safety concerns emerge, the QIDP will work with the team to develop additional supports as needed</p> <p>The Residential Manager will turn in copies of completed</p>				

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	<p>emergency department via ambulance. ER (Emergency Room) personnel diagnosed the (sic) [FC #1] with a laceration which required sutures and closed nasal fracture. [Client #1] received a no contact order with his (sic) [FC #1] and was released to ResCare staff. [FC #1] has requested to be housed outside of the facility pending approval of an emergency waiver from BDDS.</p> <p>Plan to Resolve. [FC #1] is staying at a [hotel] with staff support while ResCare and BDDS assist [FC #1] with exploring residential options. The team is investigating the circumstances of (sic) and staff response to the incident. [Staff #1] had checked on the individuals immediately prior to the incident and no problems were noted. ResCare nursing will monitor [FC #1's] recovery."</p> <p>The review did not indicate documentation of an investigation regarding client #1's 7/27/14 assault on FC #1.</p> <p>-BDDS report dated 8/10/14 indicated on 8/9/14 "[Client #2] ran into the living (sic) and stated that [client #1] was hitting and kicking him. As staff was talking to [client #2], [client #1] ran out (sic) the room and started to kick [client #2] again, (sic) staff immediately intervened (sic) altercation, (sic) staff</p>		<p>investigations to the Clinical Supervisor responsible for Quality Assurance to allow for appropriate oversight and follow-up. The Clinical Supervisor will follow-up with the Residential Manager as needed but no less than weekly to review incident documentation and completed investigations to assure they have been completed thoroughly.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

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	<p>redirected [client #1] back to his room but instead of him going back to his room he went to the kitchen and grabbed a fork and tried to stab [client #2]. Staff intervened and retrieved the fork and tired (sic) to redirect [client #1] back to his room but [client #1] ran out (sic) the house and staff ran after him to make sure that he was safe and to redirect him back in the house. [Client #1] returned 5 minutes later with staff and was in the continuous line of sight. Staff completed a body check on [client #2] to see if he had any marks on him and he just had a mark on his left leg. Facility nurse and the administration team were immediately notified. Staff applied first aid to [client #2's] leg per the nurse." The 8/10/14 BDDS report indicated, "Plan to resolve. Administrative team took [client #1] to [hospital] for a psychological evaluation."</p> <p>The review did not indicate documentation of an investigation regarding client #1's 8/10/14 assault on client #2.</p> <p>-BDDS report dated 8/11/14 indicated on 8/10/14 "[Client #7] was standing in the living room when [client #1] came and attempted to kick [client #7] in the face." The 8/11/14 BDDS report indicated, "Plan to resolve. Team will follow the</p>			

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	<p>ISP (Individual Support Plan) and BSP for all consumers. [Client #1] went to [hospital] for a psychological evaluation. Staff will monitor [client #1] every 15 minutes."</p> <p>The review did not indicate documentation of an investigation regarding client #1's 8/11/14 assault on client #7.</p> <p>CS (Clinical Supervisor) #2 was asked to provide documentation of investigations regarding client #1's 7/18/14 knife incident with FC #1, client #1's assault on FC #1 resulting in injury, client #1's assault on client #7 and client #1's 8/11/14 assault on client #2 via electronic mail correspondence on 9/16/14 at 3:37 PM. CS #1 indicated via reply electronic mail correspondence "I have instructed [RM (Residential Manager) #1] to give them (investigations) to you." No additional documentation of investigations was provided at day three of review (9/18/14).</p> <p>Client #1's record was reviewed on 9/17/14 at 3:59 PM. Client #1's record did not indicate documentation of the facility conducting IDT (Interdisciplinary Team) meetings to develop measures to address/prevent further incidents of client #1's physical attacks on his housemates.</p>			

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	<p>CS #2 provided IDT notes regarding client #1 via electronic mail correspondence on 9/18/14 at 5:04 PM. The review indicated the following IDT notes:</p> <p>-IDT note dated 7/18/14 indicated, "HRC (Human Rights Committee) approval will be obtained to lock up all sharps (knives)." The IDT note did not indicate documentation of recommendations regarding how staff were to monitor client #1, interventions to address client #1's assaulting behaviors or review of client #1's BSP to determine if additional supports were needed to prevent additional incidents of client #1's physical aggression towards his housemates.</p> <p>-IDT note dated 7/22/14 indicated, "Staff will know where [client #1] is and redirect him to a positive situation when he cannot control his temper. [Client #1] will not throw objects at the staff or his housemates." The IDT note did not indicate documentation regarding how staff were to implement the recommendation to "know where [client #1] is." The IDT note did not indicate documentation regarding IDT review of client #1's BSP or if additional supports were needed to prevent further incidents</p>			
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	<p>of client #1's physical aggression towards his housemates.</p> <p>-IDT note dated 7/28/14 indicated, "HRC approval was obtained to lock all sharp objects."</p> <p>-IDT note dated 8/11/14 indicated, "[Client #1] will be monitored and redirected when he is increasing himself (sic) in negative behaviors. [Client #1] will not hit or fight anyone. Staff will follow his (unknown). Staff will monitor [client #1] when using all silverware."</p> <p>The review did not indicate documentation of the development of or implementation of systemic programming or behavioral interventions to prevent client #1's aggressive behaviors towards his housemates.</p> <p>2. The facility's BDDS reports and investigations were reviewed on 9/16/14 at 1:32 PM. The review indicated the following:</p> <p>-BDDS report dated 9/12/14 indicated, "[Client #3] was in (sic) living room with staff. [Client #3] stated he wanted to lay back down (sic) staff told him that was fine and he would come and wake him for morning medications. When staff went to wake [client #3] (sic) was not in</p>			

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	<p>(sic) room. Staff immediately called (sic) on call team and was instructed to go look for [client #3]. Staff called on call back about an hour later stating he could not find him. On call [RM #2] immediately came to [group home] to file a missing persons report. [RM #2] of home (sic) also went out to find [client #3] and was unable to locate him. Plan to resolve. Staff will keep [client #3] in eye sight at all times. Staff will check on [client #3] every 15 minutes on overnights and any time [client #3] is in his bedroom. Staff will contact (the) administration team and follow [client #3] if he leaves (the) home."</p> <p>CS #1 was interviewed on 9/16/14 at 3:41 PM. CS #1 indicated client #3 had been an emergency placement to the group home on the evening of 9/11/14. CS #1 indicated upon waking his first morning in the group home client #3 told staff that he needed to go to his school. CS #1 indicated the facility was not aware of client #3 attending school. CS #1 indicated client #3 left the group home and was able to make his way to his high school. CS #1 indicated client #3 was located on 9/12/14 at his high school. CS #1 indicated client #3 was placed on line of sight supervision with 15 minute checks during overnight hours and door alarms had been installed on the doors at</p>			
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	<p>the group home.</p> <p>-BDDS report dated 9/16/14 indicated on 9/15/14 "[Client #3] (sic) while staff was passing medications and making breakfast [client #3] went out (sic) back door without staff knowing. When staff went to get [client #3] for morning medications he was gone. Staff immediately contacted on call team and was instructed to look for him. Staff was unable to find [client #3] and contacted [RM #1] of (the) home who also went out to search. Police was (sic) called and missing person report was made when they where (sic) still unable to find him." The BDDS report indicated client #3 was not in staff's sight at the time of client #3's elopement from the group home.</p> <p>Observations were conducted at the group home on 9/17/14 from 12:15 PM through 1:36 PM. At 12:16 PM client #3 was seated in the group home's dining room area eating lunch. Staffs #1 and #2, the two staff on duty, were both in the group home's medication administration room with the door closed. Client #3 was not in staff's line of sight. At 12:18 PM, client #3 entered the group home's living room area to talk to RM #1, who had just arrived at the group home. Client #3 spoke to RM #1 then returned to the dining area. RM #1, staff #1 and staff #2</p>			
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	<p>returned to the medication administration room while client #3 resumed eating his lunch in the dining room area. Client #3 was not in staff's line of sight. At 12:20 PM, RM #1, staff #1 and staff #2 were in the medication administration room while client #3 finished eating his lunch and walked from the group home's dining room area to his bedroom. At 12:24 PM, client #3 returned to the kitchen area where staff were then present.</p> <p>Client #3's record was reviewed on 9/17/14 at 10:45 AM. Client #3's IDT note dated 9/12/14 indicated, "[Client #3] will be monitored and placed on 15 minute checks to ensure safety is met. Staff will know where he is at all times. [Client #3] also will be placed on line of site (sic)."</p> <p>RM #1 was interviewed on 9/18/14 at 11:30 AM. RM #1 indicated client #3 had been located on 9/15/14 at his high school. RM #1 indicated client #3 should be in line of sight during waking hours and on 15 minute checks during overnight hours.</p> <p>3. The facility's BDDS reports, IRs and investigations were reviewed on 9/16/14 at 1:32 PM. The review indicated the following:</p>			

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	<p>-IR dated 7/6/14 at 12:23 AM indicated, "[Client #4] was standing in (the) living room crying. When staff asked him what was wrong, [client #4] took off running out of site. Line of sight was kept until [client #4] reached [street]. On call was notified. [Client #4] was returned to (the) site by on call RM (Resident Manager) at 1:00 AM."</p> <p>-Elopement/Missing Person Investigation Summary (EMPIS) dated 7/6/14 indicated,</p> <p>-"How long was the client gone? Thirty seven minutes."</p> <p>-"[Client #4] requires 24 hour supervision and receives 24-7 staff support."</p> <p>-"Was the client at risk to himself/herself or others? [Client #4] lives with mental illness and lacks sound judgement and therefore was considered at risk while he was without direct supervision."</p> <p>-"What is the history of previous elopement/missing person of this client? [Client #4] frequently leaves his assigned area, but staff are normally able to follow and redirect him. [Client #4] has eloped in the past but the behavior was removed from his BSP (Behavior Support Plan)</p>			

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	<p>due to a lack of occurrences."</p> <p>- "What measures are in place to prevent this in the future? The IDT (Interdisciplinary Team) will meet to arrange re-implementation of supports that address elopement."</p> <p>- IR dated 7/6/14 at 8:30 AM indicated, "[Client #4] just walk out around 8:30 PM (sic) and staff get in the van and start chasing him from [street] to [street] (sic) and those passing by people call police on him before he can be able to stop (sic), the police ask [client #4] what happened (sic) and he lie (sic) to police man that his roommate was beaten (sic) him and police ask him to enter the van and follow come (sic) home with the police man (sic) and police man ask [client #8], [client #4's] roommate that (sic) what happen between him and [client #4] and [client #8] said nothing happen between him (sic) and [client #4] and staff explain to police man that [client #4] was lie (sic) and the police man said that he already know (sic) that [client #4] was lie (sic) and even (sic) that the staff are really doing a good job. Then after his medications [client #4] use (sic) the back door and ran away and we started looking for him."</p> <p>- BDDS report dated 7/7/14 indicated,</p>						

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	<p>"[Client #4] walked out of the home's front door and [staff #1] followed. [Client #4] began pacing back and forth across the street and a passing motorist called the police. When the police arrived, [client #4] began making a series of delusional remarks. Staff and the police convinced [client #4] to return inside the house. Police interviewed staff and [client #4's] housemates and they suggested [client #4] would benefit from an emergency psychiatric evaluation. Staff transported [client #4] to the ER (Emergency Room) where he was diagnosed with paranoia and released to ResCare staff. Plan to resolve. [Client #4] remained calm for the duration of the night. Delusional behavior is not specifically addressed in [client #4's] current BSP. The team will meet to discuss revision to the BSP."</p> <p>The 7/7/14 BDDS report did not indicate documentation of client #4's allegation regarding his roommate and client #4's second elopement incident after being returned to the group home.</p> <p>The review did not indicate documentation of an investigation regarding client #4's 7/6/14 allegation regarding his roommate client #8. The review did not indicate documentation of an EMPIS being completed.</p>			

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	<p>-BDDS report dated 9/8/14 indicated, "[Client #4] became agitated upon completion of his psychological appointment. [Client #4] began to walk away from staff out of the building and down the street. Staff verbally tried to redirect [client #4] to please stop. While [client #4] was still in line of sight staff quickly got into his vehicle and came out of the other parking lot with the hope's (sic) of coaching [client #4] into the vehicle [client #4] still refused. Staff then parked the car and began to walk and talk with [client #4] explaining that this was very dangerous behavior. Still upset [client #4] began to dart across a busy intersection, following his BSP staff quickly intervened utilizing the basic technique YSIS (You're Safe, I'm Safe) (physical restraint) with open hands (sic) staff physically redirected [client #4] back on to the sidewalk. [Client #4] was not in anyway injured as a result to (sic) using the technique. [Client #4] did get into the vehicle and staff applied emotional support. The administrative team and [client #4's] guardian have been notified of this incident. Plan to resolve. Utilizing the basic technique YSIS is a apart (sic) of [client #4's] current plan. Staff will continue to follow his plan to insure that [client #4] remains safe."</p>			

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	<p>Client #4's record was reviewed on 9/17/14 at 3:35 PM. Client #4's record did not indicate documentation of IDT review of client #4's elopement behaviors.</p> <p>CS #2 provided IDT notes regarding client #4 via electronic mail correspondence on 9/18/14 at 5:04 PM. Client #4's IDT note dated 7/6/14 indicated, "Staff will re-direct [client #4] when he is engaged in negative behavior. Staff will chart on a 15 minute check to insure that his safety is being met." The review did not indicate IDT discussion/review of client #4's BSP regarding delusional behavior or elopement behavior.</p> <p>Client #4's BSP dated 9/1/14 did not include/identify delusional or elopement behaviors as target behaviors for client #4. Client #4's BSP did not indicate documentation of specifically how staff should prevent or support client #4 during incidents of delusional or elopement behaviors. Client #4's BSP did not indicate staff should utilize basic YSIS techniques to address client #4's elopement behaviors.</p> <p>CS #2 was interviewed on 9/18/14 at 11:30 AM. CS #2 indicated the facility's abuse and neglect policy should be</p>			

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	<p>implemented. CS #2 indicated allegations of abuse, neglect and mistreatment should be investigated. CS #2 indicated the IDT or administrative team should develop and implement corrective actions to prevent abuse, neglect and mistreatment.</p> <p>The facility's policy and procedures were reviewed on 9/22/14 at 1:17 PM. The facility's Abuse, Neglect, Exploitation and Mistreatment policy dated 2/26/11 indicated, "Adept staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect, exploitation or mistreatment shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated and the policies of Adept, ResCare and local state and federal guidelines." The 2/26/11 policy included the following definitions:</p> <p>- "Physical abuse: the act or failure to act that results or could result in physical injury to an individual. Non-accidental injury inflicted by another person or persons."</p> <p>- "Intimidation/emotional abuse: the act or failure to act that results or could result in emotional injury to an individual. The act of insulting or coarse language or</p>			

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	<p>gestures directed toward and 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 individuals psychological and social well being."</p> <p>The facility's Investigations policy dated 9/14/07 indicated, "In order to ensure the health, safety and welfare of the people we support, events or collections of circumstances that are outside of what is normally expected, cannot by (sic) explained and understood by the existence of the even and result in or have the potential to result in injury or abuse, neglect or exploitation to the consumer must be investigated. Investigations will be conducted per the protocols listing in the incident management best practices manual."</p> <p>The 9/14/07 policy indicated, "A thorough investigation final report will be written at the completion of the investigation. The report shall include, but it not limited to the following: ...</p>			

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W000154	<p>methods to prevent future incidents."</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 5 of 26 allegations of abuse, neglect and mistreatment reviewed, the facility failed to provide documentation of investigations regarding 4 separate incidents of physical aggression regarding client #1 and 1 allegation of abuse/mistreatment and elopement regarding client #4.</p> <p>Findings include:</p> <p>1. The facility's BDDS (Bureau of Developmental Disabilities Services) reports, IRs (Incident Reports) and investigations were reviewed on 9/16/14 at 1:32 PM. The review indicated the following:</p> <p>-BDDS report dated 7/19/14 indicated on 7/18/14 "While staff assisted the clients with cooking breakfast, [client #1] grabbed a knife off the counter while in the kitchen and placed it to the throat of</p>	W000154	<p>CORRECTION:</p> <p><i>The facility must have evidence that all alleged violations are thoroughly investigated.</i> Specifically, the Residential Manager has been retrained on components of a thorough investigation, specifically that all potential witnesses must be interviewed and all relevant documents reviewed, as well as the need to reproduce copies of investigation reports to medical surveyors upon request.</p> <p>PREVENTION:</p> <p>The Residential Manager will turn in copies of completed investigations to the Clinical Supervisor responsible for Quality Assurance to allow for appropriate oversight and follow-up. The Clinical Supervisor will follow-up with the Residential Manager as needed but no less</p>	10/24/2014

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	<p>[FC (Former Client) #1]. Staff quickly intervened using verbal prompts asking [client #1] to put down the knife. [Client #1] quickly complied putting the knife back on the counter. The staff redirected [client #1] by asking him to please leave the kitchen area, [client #1] quickly complied. Staff then began to supply emotional support to [FC #1] asking him was he ok, he said yes (sic). There was no visible injuries (sic) as a result of this incident. When asking [client #1] to please explain his actions, he stated that in the book that he had read back at his old placement 'That's what all rivals do.'"</p> <p>The review did not indicate documentation of an investigation regarding the 7/18/14 incident of client #1's attempted assault of FC #1.</p> <p>2. BDDS report dated 7/28/14 indicated on 7/27/14 "A housemate, [client #1], was in [FC #1's] bedroom visiting. Without apparent antecedent, [client #1], kicked a (sic) [FC #1] in the nose. [FC #1] ran out of the room and called 911. Police arrived and arrested [client #1] and [FC #1] was transported to the [hospital] emergency department via ambulance. ER (Emergency Room) personnel diagnosed the (sic) [FC #1] with a laceration which required sutures and closed nasal fracture. [Client #1] received</p>		<p>than weekly to review incident documentation and completed investigations to assure they have been completed thoroughly.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

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	<p>a no contact order with his (sic) [FC #1] and was released to ResCare staff. [FC #1] has requested to be housed outside of the facility pending approval of an emergency waiver from BDDS."</p> <p>The review did not indicate documentation of an investigation regarding client #1's 7/27/14 assault on FC #1.</p> <p>3. BDDS report dated 8/10/14 indicated on 8/9/14 "[Client #2] ran into the living (sic) and stated that [client #1] was hitting and kicking him. As staff was talking to [client #2], [client #1] ran out (sic) the room and started to kick [client #2] again, (sic) staff immediately intervened (sic) altercation, (sic) staff redirected [client #1] back to his room but instead of him going back to his room he went to the kitchen and grabbed a fork and tried to stab [client #2]. Staff intervened and retrieved the fork and tired (sic) to redirect [client #1] back to his room but [client #1] ran out (sic) the house and staff ran after him to make sure that he was safe and to redirect him back in the house. [Client #1] returned 5 minutes later with staff and was in the continuous line of sight. Staff completed a body check on [client #2] to see if he had any marks on him and he just had a mark on his left leg. Facility nurse and</p>			

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	<p>the administration team were immediately notified. Staff applied first aid to [client #2's] leg per the nurse."</p> <p>The review did not indicate documentation of an investigation regarding client #1's 8/10/14 assault on client #2.</p> <p>4. BDDS report dated 8/11/14 indicated on 8/10/14 "[Client #7] was standing in the living room when [client #1] came and attempted to kick [client #7] in the face."</p> <p>The review did not indicate documentation of an investigation regarding client #1's 8/11/14 assault on client #7.</p> <p>CS (Clinical Supervisor) #2 was asked to provide documentation of investigations regarding client #1's 7/18/14 knife incident with FC #1, client #1's assault on FC #1 resulting in injury, client #1's assault on client #7 and client #1's 8/11/14 assault on client #2 via electronic mail correspondence on 9/16/14 at 3:37 PM. CS #1 indicated via reply electronic mail correspondence "I have instructed [RM (Residential Manager) #1] to give them (investigations) to you." No additional documentation of investigations was provided at day three</p>			

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	<p>of review (9/18/14).</p> <p>5. The facility's BDDS reports, IRs and investigations were reviewed on 9/16/14 at 1:32 PM. The review indicated the following:</p> <p>-IR dated 7/6/14 at 8:30 AM indicated, "[Client #4] just walk out around 8:30 PM (sic) and staff get in the van and start chasing him from [street] to [street] (sic) and those passing by people call police on him before he can be able to stop (sic), the police ask [client #4] what happened (sic) and he lie (sic) to police man that his roommate was beaten (sic) him and police ask him to enter the van and follow come (sic) home with the police man (sic) and police man ask [client #8], [client #4's] roommate that (sic) what happen between him and [client #4] and [client #8] said nothing happen between him (sic) and [client #4] and staff explain to police man that [client #4] was lie (sic) and the police man said that he already know (sic) that [client #4] was lie (sic) and even (sic) that the staff are really doing a good job. Then after his medications [client #4] use (sic) the back door and ran away and we started looking for him."</p> <p>-BDDS report dated 7/7/14 indicated, "[Client #4] walked out of the home's</p>			
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	<p>front door and [staff #1] followed. [Client #4] began pacing back and forth across the street and a passing motorist called the police. When the police arrived, [client #4] began making a series of delusional remarks. Staff and the police convinced [client #4] to return inside the house. Police interviewed staff and [client #4's] housemates and they suggested [client #4] would benefit from an emergency psychiatric evaluation. Staff transported [client #4] to the ER (Emergency Room) where he was diagnosed with paranoia and released to ResCare staff. Plan to resolve. [Client #4] remained calm for the duration of the night. Delusional behavior is not specifically addressed in [client #4's] current BSP. The team will meet to discuss revision to the BSP."</p> <p>The review did not indicate documentation of an investigation regarding client #4's 7/6/14 allegation regarding his roommate client #8. The review did not indicate documentation of an Elopement/Missing Person Investigation Summary being completed regarding client #4's 7/6/14 elopement.</p> <p>CS #2 was interviewed on 9/18/14 at 11:30 AM. CS #2 indicated allegations of abuse, neglect and mistreatment should be investigated.</p>			

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W000157	<p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review and interview for 8 of 26 allegations of abuse, neglect and mistreatment reviewed, the facility failed to develop and implement corrective measures to prevent further incidents of client #1's physical aggression and intimidating behavior and clients #3 and #4's elopement behaviors.</p> <p>Findings include:</p> <p>1. The facility's BDDS (Bureau of Developmental Disabilities Services) reports, IRs (Incident Reports) and investigations were reviewed on 9/16/14 at 1:32 PM. The review indicated the following:</p> <p>-BDDS report dated 7/19/14 indicated on 7/18/14 "While staff assisted the clients with cooking breakfast, [client #1] grabbed a knife off the counter while in the kitchen and placed it to the throat of [FC (Former Client) #1]. Staff quickly intervened using verbal prompts asking [client #1] to put down the knife. [Client #1] quickly complied putting the knife</p>	W000157	<p>CORRECTION:</p> <p><i>If the alleged violation is verified, appropriate corrective action must be taken. Specifically:</i></p> <p>The facility is working with the Bureau of Developmental Disability Services to obtain an Emergency Medicaid Waiver to provide Client #1 with a residential placement that more appropriately meets client #1's Developmental, social and behavioral needs. In the interim, BDDS has agreed to assist with finding temporary placement in a more secure residential facility.</p> <p>Specifically for Clients #3 and #4, the interdisciplinary team will develop additional safeguards and procedures to address elopement behavior.</p> <p>PREVENTION:</p>	10/24/2014
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	<p>back on the counter. The staff redirected [client #1] by asking him to please leave the kitchen area, [client #1] quickly complied. Staff then began to supply emotional support to [FC #1] asking him was he ok, he said yes (sic). There was no visible injuries (sic) as a result of this incident. When asking [client #1] to please explain his actions, he stated that in the book that he had read back at his old placement "That's what all rivals do." The 7/19/14 BDDS report indicated, "[Client #1] does have a BSP (Behavior Support Plan) that does display (sic) physical and verbal aggression. [Client #1] has been transitioned into this home for 2 weeks. It is apparent that through guidance [client #1] will need to understand that he no longer resides in a locked facility. The team has expressed consequently that through monitoring of communication and the importance of active listening this may be (sic) the important steps in building positive relationships with his housemates. Staff will continue to follow [client #1's] BSP. The staff will also continue to be alert and aware preventing any pre behavior situations that may occur."</p> <p>-BDDS report dated 7/28/14 indicated on 7/27/14 "A housemate, [client #1], was in [FC #1's] bedroom visiting. Without apparent antecedent, [client #1], kicked a</p>		<p>The governing body will assist with screening referrals for admission to the facility to assure they possess similar developmental, social and behavioral needs to the other clients residing in the facility. Final approval for admission will be contingent on the ability to maintain safety and emotional stability at the facility. The QIDP will bring all relevant elements of the interdisciplinary team together after serious incidents including but not limited to physical aggression and intimidation and elopement to review current supports and to make adjustments and revisions as needed. The QIDP will turn in copies of post-incident interdisciplinary team meeting notes to the Program Manager and Clinical Supervisor to allow for appropriate oversight and follow-up. The Clinical Supervisor will meet weekly with the QIDP to review incidents which require interdisciplinary team action. When patterns of physical aggression and intimidation emerge, the Operations Team will assist the facility for assessing whether client(s) remain an appropriate fit for the facility and take action toward finding alternative placement when appropriate. When patterns of elopement or other safety concerns emerge, the QIDP will work with the team to develop additional supports as needed</p>				

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	<p>(sic) [FC #1] in the nose. [FC #1] ran out of the room and called 911. Police arrived and arrested [client #1] and [FC #1] was transported to the [hospital] emergency department via ambulance. ER (Emergency Room) personnel diagnosed the (sic) [FC #1] with a laceration which required sutures and closed nasal fracture. [Client #1] received a no contact order with his (sic) [FC #1] and was released to ResCare staff. [FC #1] has requested to be housed outside of the facility pending approval of an emergency waiver from BDDS. Plan to Resolve. [FC #1] is staying at a [hotel] with staff support while ResCare and BDDS assist [FC #1] with exploring residential options. The team is investigating the circumstances of (sic) and staff response to the incident. [Staff #1] had checked on the individuals immediately prior to the incident and no problems were noted. ResCare nursing will monitor [FC #1's] recovery."</p> <p>-BDDS report dated 8/10/14 indicated on 8/9/14 "[Client #2] ran into the living (sic) and stated that [client #1] was hitting and kicking him. As staff was talking to [client #2], [client #1] ran out (sic) the room and started to kick [client #2] again, (sic) staff immediately intervened (sic) altercation, (sic) staff redirected [client #1] back to his room</p>		<p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	
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	<p>but instead of him going back to his room he went to the kitchen and grabbed a fork and tried to stab [client #2]. Staff intervened and retrieved the fork and tired (sic) to redirect [client #1] back to his room but [client #1] ran out (sic) the house and staff ran after him to make sure that he was safe and to redirect him back in the house. [Client #1] returned 5 minutes later with staff and was in the continuous line of sight. Staff completed a body check on [client #2] to see if he had any marks on him and he just had a mark on his left leg. Facility nurse and the administration team were immediately notified. Staff applied first aid to [client #2's] leg per the nurse." The 8/10/14 BDDS report indicated, "Plan to resolve. Administrative team took [client #1] to [hospital] for a psychological evaluation."</p> <p>-BDDS report dated 8/11/14 indicated on 8/10/14 "[Client #7] was standing in the living room when [client #1] came and attempted to kick [client #7] in the face." The 8/11/14 BDDS report indicated, "Plan to resolve. Team will follow the ISP (Individual Support Plan) and BSP for all consumers. [Client #1] went to [hospital] for a psychological evaluation. Staff will monitor [client #1] every 15 minutes."</p>			
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	<p>Client #1's record was reviewed on 9/17/14 at 3:59 PM. Client #1's record did not indicate documentation of the facility conducting IDT (Interdisciplinary Team) meetings to develop measures to address/prevent further incidents of client #1's physical attacks on his housemates.</p> <p>CS #2 provided IDT notes regarding client #1 via electronic mail correspondence on 9/18/14 at 5:04 PM. The review indicated the following IDT notes:</p> <p>-IDT note dated 7/18/14 indicated, "HRC (Human Rights Committee) approval will be obtained to lock up all sharps (knives)." The IDT note did not indicate documentation of recommendations regarding how staff were to monitor client #1, interventions to address client #1's assaulting behaviors or review of client #1's BSP to determine if additional supports were needed to prevent additional incidents of client #1's physical aggression towards his housemates.</p> <p>-IDT note dated 7/22/14 indicated, "Staff will know where [client #1] is and redirect him to a positive situation when he cannot control his temper. [Client #1] will not throw objects at the staff or his housemates." The IDT note did not</p>			

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	<p>indicate documentation regarding how staff were to implement the recommendation to "know where [client #1] is." The IDT note did not indicate documentation regarding IDT review of client #1's BSP or if additional supports were needed to prevent further incidents of client #1's physical aggression towards his housemates.</p> <p>-IDT note dated 7/28/14 indicated, "HRC approval was obtained to lock all sharp objects."</p> <p>-IDT note dated 8/11/14 indicated, "[Client #1] will be monitored and redirected when he is increasing himself (sic) in negative behaviors. [Client #1] will not hit or fight anyone. Staff will follow his (unknown). Staff will monitor [client #1] when using all silverware."</p> <p>The review did not indicate documentation of the development of or implementation of systemic programming or behavioral interventions to prevent client #1's aggressive behaviors towards his housemates.</p> <p>2. The facility's BDDS reports and investigations were reviewed on 9/16/14 at 1:32 PM. The review indicated the following:</p>			

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	<p>-BDDS report dated 9/12/14 indicated, "[Client #3] was in (sic) living room with staff. [Client #3] stated he wanted to lay back down (sic) staff told him that was fine and he would come and wake him for morning medications. When staff went to wake [client #3] (sic) was not in (sic) room. Staff immediately called (sic) on call team and was instructed to go look for [client #3]. Staff called on call back about an hour later stating he could not find him. On call [RM #2] immediately came to [group home] to file a missing persons report. [RM #2] of home (sic) also went out to find [client #3] and was unable to locate him. Plan to resolve. Staff will keep [client #3] in eye sight at all times. Staff will check on [client #3] every 15 minutes on overnights and any time [client #3] is in his bedroom. Staff will contact (the) administration team and follow [client #3] if he leaves (the) home."</p> <p>CS #1 was interviewed on 9/16/14 at 3:41 PM. CS #1 indicated client #3 had been an emergency placement to the group home on the evening of 9/11/14. CS #1 indicated upon waking his first morning in the group home client #3 told staff that he needed to go to his school. CS #1 indicated the facility was not aware of client #3 attending school. CS #1 indicated client #3 left the group home</p>				

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	<p>and was able to make his way to his high school. CS #1 indicated client #3 was located on 9/12/14 at his high school. CS #1 indicated client #3 was placed on line of sight supervision with 15 minute checks during overnight hours and door alarms had been installed on the doors at the group home.</p> <p>-BDDS report dated 9/16/14 indicated on 9/15/14 "[Client #3] (sic) while staff was passing medications and making breakfast [client #3] went out (sic) back door without staff knowing. When staff went to get [client #3] for morning medications he was gone. Staff immediately contacted on call team and was instructed to look for him. staff was unable to find [client #3] and contacted [RM #1] of (the) home who also went out to search. Police was called and missing person report was made when they where still able to find him." The BDDS report indicated client #3 was not in staff's sight at the time of client #3's elopement from the group home.</p> <p>Observations were conducted at the group home on 9/17/14 from 12:15 PM through 1:36 PM. At 12:16 PM client #3 was seated in the group home's dining room area eating lunch. Staffs #1 and #2, the two staff on duty, were both in the group home's medication administration</p>			

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	<p>room with the door closed. Client #3 was not in staff's line of sight. At 12:18 PM, client #3 entered the group home's living room area to talk to RM #1, who had just arrived at the group home. Client #3 spoke to RM #1 then returned to the dining area. RM #1, staff #1 and staff #2 returned to the medication administration room while client #3 resumed eating his lunch in the dining room area. Client #3 was not in staff's line of sight. At 12:20 PM, RM #1, staff #1 and staff #2 were in the medication administration room while client #3 finished eating his lunch and walked from the group home's dining room area to his bedroom. At 12:24 PM, client #3 returned to the kitchen area where staff were then present.</p> <p>Client #3's record was reviewed on 9/17/14 at 10:45 AM. Client #3's IDT note dated 9/12/14 indicated, "[Client #3] will be monitored and placed on 15 minute checks to ensure safety is met. Staff will know where he is at all times. [Client #3] also will be placed on line of site (sic)."</p> <p>RM #1 was interviewed on 9/18/14 at 11:30 AM. RM #1 indicated client #3 had been located on 9/15/14 at his high school. RM #1 indicated client #3 should be in line of sight during waking hours and on 15 minute checks during</p>			

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	<p>overnight hours.</p> <p>3. The facility's BDDS reports, IRs and investigations were reviewed on 9/16/14 at 1:32 PM. The review indicated the following:</p> <p>-IR dated 7/6/14 at 12:23 AM indicated, "[Client #4] was standing in (the) living room crying. When staff asked him what was wrong, [client #4] took off running out of site. Line of sight was kept until [client #4] reached [street]. On call was notified. [Client #4] was returned to (the) site by on call RM (Resident Manager) at 1:00 AM."</p> <p>-Elopement/Missing Person Investigation Summary (EMPIS) dated 7/6/14 indicated,</p> <p>-"How long was the client gone? Thirty seven minutes."</p> <p>-"[Client #4] requires 24 hour supervision and receives 24-7 staff support."</p> <p>-"Was the client at risk to himself/herself or others? [Client #4] lives with mental illness and lacks sound judgement and therefore was considered at risk while he was without direct supervision."</p>			
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	<p>- "What is the history of previous elopement/missing person of this client? [Client #4] frequently leaves his assigned area, but staff are normally able to follow and redirect him. [Client #4] has eloped in the past but the behavior was removed from his BSP (Behavior Support Plan) due to a lack of occurrences."</p> <p>- "What measures are in place to prevent this in the future? The IDT (Interdisciplinary Team) will meet to arrange re-implementation of supports that address elopement."</p> <p>- IR dated 7/6/14 at 8:30 AM indicated, "[Client #4] just walk out around 8:30 PM (sic) and staff get in the van and start chasing him from [street] to [street] (sic) and those passing by people call police on him before he can be able to stop (sic), the police ask [client #4] what happened (sic) and he lie (sic) to police man that his roommate was beaten (sic) him and police ask him to enter the van and follow come (sic) home with the police man (sic) and police man ask [client #8], [client #4's] roommate that (sic) what happen between him and [client #4] and [client #8] said nothing happen between him (sic) and [client #4] and staff explain to police man that [client #4] was lie (sic) and the police man said that he already know (sic) that [client #4] was lie (sic)</p>			

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	<p>and even (sic) that the staff are really doing a good job. Then after his medications [client #4] use (sic) the back door and ran away and we started looking for him."</p> <p>-BDDS report dated 7/7/14 indicated, "[Client #4] walked out of the home's front door and [staff #1] followed. [Client #4] began pacing back and forth across the street and a passing motorist called the police. When the police arrived, [client #4] began making a series of delusional remarks. Staff and the police convinced [client #4] to return inside the house. Police interviewed staff and [client #4's] housemates and they suggested [client #4] would benefit from an emergency psychiatric evaluation. Staff transported [client #4] to the ER (Emergency Room) where he was diagnosed with paranoia and released to ResCare staff. Plan to resolve. [Client #4] remained calm for the duration of the night. Delusional behavior is not specifically addressed in [client #4's] current BSP. The team will meet to discuss revision to the BSP."</p> <p>-BDDS report dated 9/8/14 indicated, "[Client #4] became agitated upon completion of his psychological appointment. [Client #4] began to walk away from staff out of the building and</p>			

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	<p>down the street. Staff verbally tried to redirect [client #4] to please stop. While [client #4] was still in line of sight staff quickly got into his vehicle and came out of the other parking lot with the hope's (sic) of coaching [client #4] into the vehicle [client #4] still refused. Staff then parked the car and began to walk and talk with [client #4] explaining that this was very dangerous behavior. Still upset [client #4] began to dart across a busy intersection, following his BSP staff quickly intervened utilizing the basic technique YSIS (You're Safe, I'm Safe) (physical restraint) with open hands (sic) staff physically redirected [client #4] back on to the sidewalk. [Client #4] was not in anyway injured as a result to (sic) using the technique. [Client #4] did get into the vehicle and staff applied emotional support. The administrative team and [client #4's] guardian have been notified of this incident. Plan to resolve. Utilizing the basic technique YSIS is a apart (sic) of [client #4's] current plan. Staff will continue to follow his plan to insure that [client #4] remains safe."</p> <p>Client #4's record was reviewed on 9/17/14 at 3:35 PM. Client #4's record did not indicate documentation of IDT review of client #4's elopement behaviors.</p>						

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	<p>CS #2 provided IDT notes regarding client #4 via electronic mail correspondence on 9/18/14 at 5:04 PM. Client #4's IDT note dated 7/6/14 indicated, "Staff will re-direct [client #4] when he is engaged in negative behavior. Staff will chart on a 15 minute check to insure that his safety is being met." The review did not indicate IDT discussion/review of client #4's BSP regarding delusional behavior or elopement behavior.</p> <p>Client #4's BSP dated 9/1/14 did not include/identify delusional or elopement behaviors as target behaviors for client #4. Client #4's BSP did not indicate documentation of specifically how staff should prevent or support client #4 during incidents of delusional or elopement behaviors. Client #4's BSP did not indicate staff should utilize basic YSIS techniques to address client #4's elopement behaviors.</p> <p>CS #2 was interviewed on 9/18/14 at 11:30 AM. CS #2 indicated the IDT or administrative team should develop and implement corrective actions to prevent abuse, neglect and mistreatment.</p> <p>9-3-2(a)</p>			

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W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the QIDP (Qualified Intellectual Disabilities Professional) failed to review/monitor client #4's objectives to determine if client #4 had successfully completed/achieved the objectives, to ensure clients #1, #2 and #4 or clients #1, #2 and #4's guardians participated in the clients' IDT (Interdisciplinary Team) meetings regarding the development of their ISP's (Individual Support Plan), to ensure clients #1 and #2's CFAs (Comprehensive Functional Assessments) were completed within 30 days of their admissions to the facility, to ensure clients #1 and #2's ISP (Individual Support Plan) objectives included specific methods of implementation, to ensure client #4's BSP (Behavior Support Plan) addressed client #4's delusional and elopement behaviors, to ensure clients #1 and #2's training objectives were documented/tracked to measure accomplishment of specified ISP (Individual Support Plan) objectives, to review/monitor client #4's objectives to determine if client #4 had successfully completed/achieved the objectives and to</p>	W000159	<p>CORRECTION:</p> <p><i>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</i></p> <p>Specifically for Client #4, the QIDP will be retrained regarding the need to conduct monthly reviews of data and documentation to determine if modifications of learning objectives are indicated no less than quarterly. Quarterly IDT review documentation will be maintained in the client's record. A review of documentation indicated this deficient practice did not affect any other clients at the facility.</p> <p>Specifically for Clients #1, #2 and #4, as well as three additional clients, #6 - #8, the QIDP and Residential Manager will be retrained regarding the need to bring all elements of the interdisciplinary team including guardian and family members, to</p>	10/24/2014

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	<p>ensure clients #1, #2, #3 and #4's use of psychotropic medication used for behavior management was conducted with the written informed consent of the clients and/or their guardians.</p> <p>Findings include:</p> <p>1. Client #4's record was reviewed on 9/17/14 at 3:35 PM. Client #4's ISP (Individual Support Plan) dated 1/22/14 indicated the following formal training objectives: will follow through to complete a task; will complete his self-care routine; will prepare a simple meal; will clean his room; will take his medication as prescribed; will make purchases learning to budget his money weekly; will choose a physical activity to participate in. Client #4's ISP indicated, "Goal implemented on 1/13/14 due to lack of progress by [RM (Resident Manager #1)]. Goal continued on 4/13/14 due to lack of progress by [RM #1]." Client #4's ISP indicated client #4's goals would be reviewed on 7/22/14. Client #4's record did not indicate documentation of review of client #4's goals, there were no monthly goal summaries and/or quarterly reviews from 4/13/14 to determine if client #4 had achieved the objectives since being implemented on 1/22/14.</p>		<p>assist with the development of individual support plans.</p> <p>The QIDP has completed a Comprehensive Functional Assessment for Clients #1 and #2. A review of facility support documents indicated this deficient practice did not affect any additional clients.</p> <p>A new QIDP has been assigned to the facility and training objectives have been put in place for Clients #1 and #2. Facility direct support staff will be trained toward proper implementation of these objectives. An audit of facility documentation indicated that this deficient practice did not affect any additional clients.</p> <p>Training objectives with specific methodologies have been put in place for Clients #1 and #2. Facility direct support staff will be trained toward proper implementation of these objectives as well as the need to document program data as directed. An audit of facility documentation indicated that this deficient practice did not affect any additional clients.</p>	

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	<p>RM #1 was interviewed on 9/18/14 at 11:04 AM. RM #1 indicated client #4's goals should be reviewed on a monthly basis to determine progression/regression of skills and goal achievement. RM #1 indicated there was not additional documentation of monthly and/or quarterly summaries to review.</p> <p>2. The QIDP failed to ensure clients #1, #2 and #4 or clients #1, #2 and #4's guardians participated in the clients' IDT meetings regarding the development of their ISP's (Individual Support Plan). Please see W209.</p> <p>3. The QIDP failed to ensure clients #1 and #2's CFAs were completed within 30 days of their admissions to the facility. Please see W210.</p> <p>4. The QIDP failed to ensure client #4's BSP addressed client #4's delusional and elopement behaviors. Please see W227.</p> <p>5. The QIDP failed to ensure clients #1 and #2's ISP (Individual Support Plan) objectives included specific methods of implementation. Please see W234.</p> <p>6. The QIDP failed to ensure clients #1 and #2's training objectives were documented/tracked to measure accomplishment of specified ISP</p>		<p>Specifically for clients #1 - #4, the team will obtain written consent from clients and legal representatives (guardians/healthcare representatives) for the use of behavior controlling medication. A review of support documents indicated this deficient practice also affected clients #4 - #8. Therefore the facility will also assure that prior written informed consent for the use of behavior controlling medication is present for these individuals as well.</p> <p>PERVENTION:</p> <p>The Governing Body has added an additional layer of supervision at the facility to assist the QIDP with focusing on support plan development and monitoring.</p> <p>The QIDP will turn in documentation of family/guardian communication to the Program Manager monthly. The Program Manager will in turn follow-up to assure that family members and guardians are invited and encouraged to participate in the ISP development process.</p> <p>The QIDP has been retrained</p>	

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	(Individual Support Plan) objectives. Please see W252. 7. The QIDP failed to ensure clients #1, #2, #3 and #4's use of psychotropic medication used for behavior management was conducted with the written informed consent of the clients and/or their guardians. Please see W263. 9-3-3(a)		regarding the need to assure that all relevant assessments are completed for clients within 30 days of admission. Members of the Operations Team will follow up with the QIDP no less twice weekly when new clients are admitted to the facility to assure appropriate assessment occurs as required. The QIDP has been trained regarding the need to track and monitor progress on all client learning objectives. Along with the QIDP, members of the Operations Team will conduct active treatment observations and reviews of support documents, to assure data is collected as required at the facility on a bi-weekly basis. The QIDP has been trained regarding the need to track and monitor progress on all client learning objectives. Along with the QIDP, members of the Operations Team will conduct active treatment observations and reviews of support documents, to assure data is collected as required at the facility on a bi-weekly basis. Professional staff will be retrained		

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W000209	483.440(c)(2) INDIVIDUAL PROGRAM PLAN Participation by the client, his or her parent		<p>regarding the need to obtain prior written informed consent from guardians, advocates and healthcare representatives for all restrictive programs prior to implementation. Retraining will focus on assuring that the QIDP has a clear understanding of what specifically constitutes a restrictive program and proper preparation for presenting program modifications guardians and other legal representatives. Prior to granting approval to restrictive programs, the Human Rights Committee will obtain confirmation that the facility has received prior written informed consent from guardians or other legal representatives. The agency has established a quarterly system of internal audits that review all facility systems including, but not limited to due process and prior written informed consent. Administrative staff will conduct visits to the facility as needed but no less than monthly.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

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	<p>(if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate.</p> <p>Based on record review and interview for 3 of 4 sampled clients (#1, #2 and #4), the facility failed to ensure clients #1, #2 and #4 or clients #1, #2 and #4's guardians participated in the clients' IDT (Interdisciplinary Team) meetings regarding the development of their ISP's (Individual Support Plan).</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 9/17/14 at 3:59 PM. Client #1's ISP dated 8/1/14 indicated client #1 was a self advocating adult with a HCR (Health Care Representative) for support. Client #1's ISP indicated, "I have been involved in the development of my ISP and I agree with this plan. I know I can appeal to the DDAR (Division of Disability, Aging and Rehabilitative Services) if I disagree with how this plan is put into action. Signed: (blank) Date: (blank)." Client #1's ISP did not indicate documentation of client #1 or client #1's HCR approval of the development of client #1's ISP. Client #1's record did not indicate documentation of client #1 or client #1's HCR/advocate participation in an IDT meeting to develop client #1's ISP.</p>	W000209	<p>CORRECTION:</p> <p><i>Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate. Specifically for Clients #1, #2 and #4, as well as three additional clients, #6 - #8, the QIDP and Residential Manager will be retrained regarding the need to bring all elements of the interdisciplinary team including guardian and family members, to assist with the development of individual support plans.</i></p> <p>PERVENTION:</p> <p>The Governing Body has added an additional layer of supervision at the facility to assist the QIDP with focusing on support plan development and monitoring. The QIDP will turn in documentation of family/guardian communication to the Program Manager monthly. The Program Manager will in turn follow-up to assure that family members and guardians are invited and encouraged to participate in the ISP development process.</p>	10/24/2014

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	<p>2. Client #2's record was reviewed on 9/17/14 at 2:35 PM. Client #2's guardianship forms dated 3/26/07 indicated client #2 had a legal guardian. Client #2's ISP indicated, "I have been involved in the development of my ISP and I agree with this plan. I know I can appeal to the DDAR if I disagree with how this plan is put into action. Signed: (blank) Date: (blank)." Client #2's ISP did not indicate documentation of client #2 or client #2's guardian's approval of the development of client #2's ISP. Client #2's record did not indicate documentation of client #2 or client #2's guardian's participation in an IDT meeting to develop client #2's ISP.</p> <p>3. Client #4's record was reviewed on 9/17/14 at 3:35 PM. Client #4's ISP dated 1/22/14 indicated client #4 had a legal guardian. Client #4's ISP indicated, "I have been involved in the development of my ISP and I agree with this plan. I know I can appeal to the DDAR if I disagree with how this plan is put into action. Signed: (blank) Date: (blank)." Client #4's ISP did not indicate documentation of client #4 or client #4's guardian's approval of the development of client #4's ISP. Client #4's record did not indicate documentation of client #4 or client #4's guardian's participation in an IDT meeting to develop client #4's ISP.</p>		<p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

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W000210	<p>CS (Clinical Supervisor) #1 was interviewed on 9/18/14 at 11:04 AM. CS #1 indicated clients #1, #2 and #4 and their guardians should participate in IDT's and be given the opportunity to participate in the development of their ISPs. CS #1 indicated there was not additional documentation of IDTs regarding clients #1, #2 or #4.</p> <p>9-3-4(a)</p> <p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on record review and interview for 2 of 4 sampled clients (#1 and #2), the facility failed to ensure clients #1 and #2's CFAs (Comprehensive Functional Assessments) were completed within 30 days of their admissions to the facility.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 9/17/14 at 3:59 PM. Client #1's Nursing Admission Assessment (NAA) dated 7/7/14 indicated client #1's date of admission to the facility was 7/7/14. Client #1's record did not indicate</p>	W000210	<p>CORRECTION:</p> <p><i>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Specifically, the QIDP has completed a Comprehensive Functional Assessment for Clients #1 and #2. A review of facility support documents indicated this deficient practice did not affect any additional clients.</i></p>	10/24/2014			

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W000227	<p>documentation of a CFA.</p> <p>2. Client #2's record was reviewed on 9/17/14 at 2:35 PM. Client #2's NAA dated 7/24/14 indicated client #2's date of admission to the facility was 7/24/14. Client #2's record did not indicate documentation of a CFA.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 9/18/14 at 11:04 AM. CS #1 indicated clients #1 and #2's CFA's should be completed within 30 days of their admissions to the facility. CS #1 indicated there was not additional documentation of CFAs for clients #1 and #2.</p> <p>9-3-4(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 record review and interview for 1 of 4 sampled clients (#4), the facility failed to ensure client #4's BSP (Behavior Support Plan) addressed client #4's</p>	W000227	<p>PERVENTION:</p> <p>The QIDP has been retrained regarding the need to assure that all relevant assessments are completed for clients within 30 days of admission. Members of the Operations Team will follow up with the QIDP no less twice weekly when new clients are admitted to the facility to assure appropriate assessment occurs as required. The Governing Body has added an additional layer of supervision at the facility to assist the QIDP with focusing on support plan development and monitoring.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION:</p> <p><i>The individual program plan states the specific objectives</i></p>	10/24/2014

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	<p>delusional and elopement behaviors.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, IRs (Incident Reports) and investigations were reviewed on 9/16/14 at 1:32 PM. The review indicated the following:</p> <p>-IR dated 7/6/14 at 12:23 AM indicated, "[Client #4] was standing in (the) living room crying. When staff asked him what was wrong, [client #4] took off running out of site. Line of sight was kept until [client #4] reached [street]. On call was notified. [Client #4] was returned to (the) site by on call RM (Resident Manager) at 1:00 AM."</p> <p>-Elopement/Missing Person Investigation Summary (EMPIS) dated 7/6/14 indicated,</p> <p>-"How long was the client gone? Thirty seven minutes."</p> <p>-"[Client #4] requires 24 hour supervision and receives 24-7 staff support."</p> <p>-"Was the client at risk to himself/herself or others? [Client #4] lives with mental</p>		<p><i>necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Specifically, a new QIDP has been assigned to the facility and training objectives have been put in place for Clients #1 and #2. Facility direct support staff will be trained toward proper implementation of these objectives. An audit of facility documentation indicated that this deficient practice did not affect any additional clients.</i></p> <p>PREVENTION:</p> <p>The QIDP has been trained regarding the need to track and monitor progress on all client learning objectives. The Governing Body has added an additional layer of supervision at the facility to assist the QIDP with focusing on support plan development and monitoring. Along with the QIDP, members of the Operations Team will conduct active treatment observations and reviews of support documents, to assure data is collected as required at the facility on a bi-weekly basis.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager,</p>	

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	<p>illness and lacks sound judgement and therefore was considered at risk while he was without direct supervision."</p> <p>-"What is the history of previous elopement/missing person of this client? [Client #4] frequently leaves his assigned area, but staff are normally able to follow and redirect him. [Client #4] has eloped in the past but the behavior was removed from his BSP (Behavior Support Plan) due to a lack of occurrences."</p> <p>-"What measures are in place to prevent this in the future? The IDT (Interdisciplinary Team) will meet to arrange re-implementation of supports that address elopement."</p> <p>-IR dated 7/6/14 at 8:30 AM indicated, "[Client #4] just walk out around 8:30 PM (sic) and staff get in the van and start chasing him from [street] to [street] (sic) and those passing by people call police on him before he can be able to stop (sic), the police ask [client #4] what happened (sic) and he lie (sic) to police man that his roommate was beaten (sic) him and police ask him to enter the van and follow come (sic) home with the police man (sic) and police man ask [client #8], [client #4's] roommate that (sic) what happen between him and [client #4] and [client #8] said nothing happen between</p>		Team Leader, Direct Support Staff, Operations Team				

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	<p>him (sic) and [client #4] and staff explain to police man that [client #4] was lie (sic) and the police man said that he already know (sic) that [client #4] was lie (sic) and even (sic) that the staff are really doing a good job. Then after his medications [client #4] use (sic) the back door and ran away and we started looking for him."</p> <p>-BDDS report dated 7/7/14 indicated, "[Client #4] walked out of the home's front door and [staff #1] followed. [Client #4] began pacing back and forth across the street and a passing motorist called the police. When the police arrived, [client #4] began making a series of delusional remarks. Staff and the police convinced [client #4] to return inside the house. Police interviewed staff and [client #4's] housemates and they suggested [client #4] would benefit from an emergency psychiatric evaluation. Staff transported [client #4] to the ER (Emergency Room) where he was diagnosed with paranoia and released to ResCare staff. Plan to resolve. [Client #4] remained calm for the duration of the night. Delusional behavior is not specifically addressed in [client #4's] current BSP. The team will meet to discuss revision to the BSP."</p> <p>The 7/7/14 BDDS report did not indicate</p>			

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	<p>documentation of client #4's allegation regarding his roommate and client #4's second elopement incident after being returned to the group home.</p> <p>The review did not indicate documentation of an investigation regarding client #4's 7/6/14 allegation regarding his roommate client #8. The review did not indicate documentation of an EMPIS being completed.</p> <p>-BDDS report dated 9/8/14 indicated, "[Client #4] became agitated upon completion of his psychological appointment. [Client #4] began to walk away from staff out of the building and down the street. Staff verbally tried to redirect [client #4] to please stop. While [client #4] was still in line of sight staff quickly got into his vehicle and came out of the other parking lot with the hope's (sic) of coaching [client #4] into the vehicle [client #4] still refused. Staff then parked the car and began to walk and talk with [client #4] explaining that this was very dangerous behavior. Still upset [client #4] began to dart across a busy intersection, following his BSP staff quickly intervened utilizing the basic technique YSIS (You're Safe, I'm Safe) (physical restraint) with open hands (sic) staff physically redirected [client #4] back on to the sidewalk. [Client #4] was</p>			

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	<p>not in anyway injured as a result to (sic) using the technique. [Client #4] did get into the vehicle and staff applied emotional support. The administrative team and [client #4's] guardian have been notified of this incident. Plan to resolve. Utilizing the basic technique YSIS is a apart (sic) of [client #4's] current plan. Staff will continue to follow his plan to insure that [client #4] remains safe."</p> <p>Client #4's record was reviewed on 9/17/14 at 3:35 PM. Client #4's record did not indicate documentation of IDT review of client #4's elopement behaviors.</p> <p>CS #2 provided IDT notes regarding client #4 via electronic mail correspondence on 9/18/14 at 5:04 PM. Client #4's IDT note dated 7/6/14 indicated, "Staff will re-direct [client #4] when he is engaged in negative behavior. Staff will chart on a 15 minute check to insure that his safety is being met." The review did not indicate IDT discussion/review of client #4's BSP regarding delusional behavior or elopement behavior.</p> <p>Client #4's BSP dated 9/1/14 did not include/identify delusional or elopement behaviors as target behaviors for client #4. Client #4's BSP did not indicate</p>			

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W000234	<p>documentation of specifically how staff should prevent or support client #4 during incidents of delusional or elopement behaviors. Client #4's BSP did not indicate staff should utilize basic YSIS techniques to address client #4's elopement behaviors.</p> <p>CS (Clinical Supervisor) #1 was interviewed on 9/18/14 at 11:04 AM. CS #1 indicated there was not additional documentation of IDTs regarding client #4's elopement/delusional behaviors and BSP supports. CS #1 indicated delusional or elopement behaviors had not been added to client #4's BSP.</p> <p>9-3-4(a)</p> <p>483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used.</p> <p>Based on record review and interview for 2 of 4 sampled clients (#1 and #2), the facility failed to ensure clients #1 and #2's ISP (Individual Support Plan) objectives included specific methods of implementation.</p>	W000234	<p>CORRECTION:</p> <p><i>Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used. Specifically a new QIDP has been assigned</i></p>	10/24/2014

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	<p>Findings include:</p> <p>1. Client #1's record was reviewed on 9/17/14 at 3:59 PM. Client #1's ISP (Individual Support Plan) dated 8/1/14 indicated the following:</p> <p>-"Support staff will implement the following objective during all skills training across environments. Given skills training, 3 VPs (Verbal Prompts), [client #1] will stay on task, 80% of the time for TCMs (Three Consecutive Months). Specific methodology is located on the page prior to his data collection page."</p> <p>-"Support staff will implement the following objective during all skills training across environments. Given skills training, 3 VPs, [client #1] will complete his daily hygiene independently 85% of the time for TCMs. Specific methodology is located on the page prior to his data collection page."</p> <p>-"Support staff will implement the following objective during all skills training across environments. Given skills training, 3 VPs, [client #1] will prepare a meal independently, 50% of the time for TCMs. Specific methodology is located on the page prior to his data collection page."</p>		<p>to the facility and training objectives with specific methodologies have been put in place for Clients #1 and #2. Facility direct support staff will be trained toward proper implementation of these objectives as well as the need to document program data as directed. An audit of facility documentation indicated that this deficient practice did not affect any additional clients.</p> <p>PREVENTION:</p> <p>The QIDP has been trained regarding the need to track and monitor progress on all client learning objectives. The Governing Body has added an additional layer of supervision at the facility to assist the QIDP with focusing on support plan development and monitoring. Along with the QIDP, members of the Operations Team will conduct active treatment observations and reviews of support documents, to assure data is collected as required at the facility on a bi-weekly basis.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

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	<p>- "Support staff will implement the following objective during all skills training across environments. Given skills training, 3 VPs, [client #1] will clean his room independently, 50% of the time for TCMs. Specific methodology is located on the page prior to his data collection page."</p> <p>- "Support staff will implement the following objective during all skills training across environments. Given skills training, 3 VPs, [client #1] will independently take his medication, 80% of the time for TCMs. Specific methodology is located on the page prior to his data collection page."</p> <p>- "Support staff will implement the following objective during all skills training across environments. Given skills training, 3 VPs, [client #1] will manage his finances independently, 75% of the time for TCMs. Specific methodology is located on the page prior to his data collection page."</p> <p>- "Support staff will implement the following objective during all skills training across environments. Given skills training, 3 VPs, [client #1] will make better choices to improve his health, 80% of the time for TCMs."</p>			

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	<p>Specific methodology is located on the page prior to his data collection page."</p> <p>Client #1's record did not indicate documentation of specific methodology of his formal training objectives.</p> <p>2. Client #2's record was reviewed on 9/17/14 at 2:35 PM. Client #2's ISP dated 8/11/14 indicated the following:</p> <p>- "Support staff will implement the following objective during all skills training across environments. Given skills training, 3 VPs, [client #2] will participate in a leisure activity, 50% of the time for TCMs. Specific methodology is located on the page prior to his data collection page."</p> <p>- "Support staff will implement the following objective during all skills training across environments. Given skills training, 3 VPs, [client #2] will prepare a meal independently, 50% of the time for TCMs. Specific methodology is located on the page prior to his data collection page."</p> <p>- "Support staff will implement the following objective during all skills training across environments. Given skills training, 3 VPs, [client #2] will state the side effects of his Risperdal</p>			

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	<p>(bipolar) independently, 50% of the time for TCMs. Specific methodology is located on the page prior to his data collection page."</p> <p>-"Support staff will implement the following objective during all skills training across environments. Given skills training, 3 VPs, [client #2] will manage his finances, 50% of the time for TCMs. Specific methodology is located on the page prior to his data collection page."</p> <p>-"Support staff will implement the following objective during all skills training across environments. Given skills training, 3 VPs, [client #2] will clean his room independently, 50% of the time for TCMs. Specific methodology is located on the page prior to his data collection page."</p> <p>-"Support staff will implement the following objective during all skills training across environments. Given skills training, 3 VPs, [client #2] will would complete his daily (hygiene) independently, 50% of the time for TCMs. Specific methodology is located on the page prior to his data collection page."</p> <p>Client #2's record did not indicate</p>			

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W000252	<p>documentation of specific methodology of his formal training objectives.</p> <p>RM (Resident Manager) #1 was interviewed on 9/18/14 at 11:04 AM. RM #1 indicated clients #1 and #2's ISP objectives methodology pages were not available for review.</p> <p>9-3-4(a)</p> <p>483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. Based on record review and interview for 2 of 4 sampled clients (#1 and #2), the facility failed to ensure clients #1 and #2's training objectives were documented/tracked to measure accomplishment of specified ISP (Individual Support Plan) objectives.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 9/17/14 at 3:59 PM. Client #1's ISP dated 8/1/14 indicated the following:</p> <p>- "Support staff will implement the</p>	W000252	<p>CORRECTION:</p> <p><i>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. Specifically, a new QIDP has been assigned to the facility and training objectives have been put in place for Clients #1 and #2. Facility direct support staff will be trained toward proper implementation of these objectives as well proper documentation of document program data. An audit of facility documentation indicated that this</i></p>	10/24/2014

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	<p>following objective during all skills training across environments. Given skills training, 3 VP (Verbal Prompts), [client #1] will stay on task, 80% of the time for TCM (Three Consecutive Months). Specific methodology is located on the page prior to his data collection page."</p> <p>-"Support staff will implement the following objective during all skills training across environments. Given skills training, 3 VP, [client #1] will complete his daily hygiene independently 85% of the time for TCM. Specific methodology is located on the page prior to his data collection page."</p> <p>-"Support staff will implement the following objective during all skills training across environments. Given skills training, 3 VP, [client #1] will prepare a meal independently, 50% of the time for TCM. Specific methodology is located on he page prior to his data collection page."</p> <p>-"Support staff will implement the following objective during all skills training across environments. Given skills training, 3 VP, [client #1] will clean his room independently, 50% of the time for TCM. Specific methodology is located on he page prior to his data</p>		<p>deficient practice did not affect any additional clients.</p> <p>PREVENTION:</p> <p>The QIDP has been trained regarding the need to track and monitor progress on all client learning objectives. The Governing Body has added an additional layer of supervision at the facility to assist the QIDP with focusing on support plan development and monitoring. Along with the QIDP, members of the Operations Team will conduct active treatment observations and reviews of support documents, to assure data is collected as required at the facility on a bi-weekly basis.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p>	

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	<p>collection page."</p> <p>-"Support staff will implement the following objective during all skills training across environments. Given skills training, 3 VP, [client #1] will independently take his medication, 80% of the time for TCM. Specific methodology is located on the page prior to his data collection page."</p> <p>-"Support staff will implement the following objective during all skills training across environments. Given skills training, 3 VP, [client #1] will manage his finances independently, 75% of the time for TCM. Specific methodology is located on the page prior to his data collection page."</p> <p>-"Support staff will implement the following objective during all skills training across environments. Given skills training, 3 VP, [client #1] will make better choices to improve his health, 80% of the time for TCM. Specific methodology is located on the page prior to his data collection page."</p> <p>Client #1's record did not indicate documentation of data collection/data collection pages regarding his formal training objectives.</p>			

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	<p>2. Client #2's record was reviewed on 9/17/14 at 2:35 PM. Client #2's ISP dated 8/11/14 indicated the following:</p> <p>- "Support staff will implement the following objective during all skills training across environments. Given skills training, 3 VPs, [client #2] will participate in a leisure activity, 50% of the time for TCMs. Specific methodology is located on the page prior to his data collection page."</p> <p>- "Support staff will implement the following objective during all skills training across environments. Given skills training, 3 VPs, [client #2] will prepare a meal independently, 50% of the time for TCMs. Specific methodology is located on the page prior to his data collection page."</p> <p>- "Support staff will implement the following objective during all skills training across environments. Given skills training, 3 VPs, [client #2] will state the side effects of his Risperdal (bipolar) independently, 50% of the time for TCMs. Specific methodology is located on the page prior to his data collection page."</p> <p>- "Support staff will implement the following objective during all skills</p>			

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	<p>training across environments. Given skills training, 3 VPs, [client #2] will manage his finances, 50% of the time for TCMs. Specific methodology is located on the page prior to his data collection page."</p> <p>-"Support staff will implement the following objective during all skills training across environments. Given skills training, 3 VPs, [client #2] will clean his room independently, 50% of the time for TCMs. Specific methodology is located on the page prior to his data collection page."</p> <p>-"Support staff will implement the following objective during all skills training across environments. Given skills training, 3 VPs, [client #2] will would complete his daily (hygiene) independently, 50% of the time for TCMs. Specific methodology is located on the page prior to his data collection page."</p> <p>Client #2's record did not indicate documentation of data collection/data collection pages regarding his formal training objectives.</p> <p>RM (Resident Manager) #1 was interviewed on 9/18/14 at 11:04 AM. RM #1 indicated clients #1 and #2's ISP</p>			

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W000263	<p>objectives should be documented on data collection pages. RM #1 indicated there was not additional documentation of data collections regarding clients #1 and #2's ISP objectives.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE 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.</p> <p>Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility's HRC (Human Rights Committee) failed to ensure clients #1, #2, #3 and #4's use of psychotropic medication used for behavior management was conducted with the written informed consent of the clients and/or their guardians.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 9/17/14 at 3:59 PM. Client #1's ISP (Individual Support Plan) dated 8/1/14 indicated client #1 was a self advocating adult with a HCR (Health Care Representative) for support. Client #1's CMF (Consent for Medication Form)</p>	W000263	<p>CORRECTION:</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 for clients #1 - #4, the team will obtain written consent from clients and legal representatives (guardians/healthcare representatives) for the use of behavior controlling medication. A review of support documents indicated this deficient practice also affected clients #4 - #8. Therefore the facility will also assure that prior written informed consent for the use of behavior controlling medication is present for these individuals as well.</i></p>	10/24/2014

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	<p>dated 8/1/14 indicated client #1 received Depakote 100 milligrams (bipolar), Lithium Carbonate 600 milligrams (bipolar), Zyprexa 20 milligrams (psychosis) and Risperdal 0.5 milligrams (bipolar). Client #1's POF (Physician Order Form) dated 8/6/14 indicated client #1 also received Strattera 40 milligrams for ADHD (Attention Deficit Hyperactivity Disorder). Client #1's CMF form dated 8/1/14 was not signed by client #1 or client #1's HCR. Client #1's record did not indicate documentation of client #1 or client #1's HCR's written informed consent. Client #1's HRC form dated 8/1/14 indicated the facility's HRC approved the use of client #1's psychotropic medications without the written informed consent of client #1 or client #1's HCR.</p> <p>2. Client #2's record was reviewed on 9/17/14 at 2:35 PM. Client #2's guardianship forms dated 3/26/07 indicated client #2 had a legal guardian. Client #2's POF dated 8/1/14 indicated client #2 received Strattera 60 milligrams (ADHD) and Risperidone 1 milligram (ADHD). Client #2's CMF dated 8/11/14 did not include Strattera 60 milligrams and was not signed by client #2 or client #2's guardian. Client #2's record did not indicate documentation of client #2 or client #2's guardian's written informed</p>		<p>PREVENTION:</p> <p>Professional staff will be retrained regarding the need to obtain prior written informed consent from guardians, advocates and healthcare representatives for all restrictive programs prior to implementation. Retraining will focus on assuring that the QIDP has a clear understanding of what specifically constitutes a restrictive program and proper preparation for presenting program modifications guardians and other legal representatives. Prior to granting approval to restrictive programs, the Human Rights Committee will obtain confirmation that the facility has received prior written informed consent from guardians or other legal representatives. The agency has established a quarterly system of internal audits that review all facility systems including, but not limited to due process and prior written informed consent. Administrative staff will conduct visits to the facility as needed but no less than monthly.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support</p>	

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	<p>consent for the use of Strattera 60 milligrams and Risperidone 1 milligram for behavior management. Client #2's HRC form dated 8/11/14 indicated the facility's HRC had approved the use of client #2's psychotropic medications without the written informed consent of client #2 or client #2's guardian.</p> <p>3. Client #3's record was reviewed on 9/17/14 at 10:45 AM. Client #3's ISP dated 9/11/14 indicated client #3 was a self advocating adult without a legal guardian. Client #3's POF dated 9/11/14 indicated client #3 received Risperdal 1 milligram (psychosis). Client #3's CMF dated 9/11/14 indicated client #3 received Risperdal 1 milligram for management of psychosis. The 9/11/14 CMF was not signed by client #3. Client #3's BSP (Behavior Support Plan) dated 9/11/14 included the use of Risperdal 1 milligrams for behavior management. Client #3's BSP was not signed by client #3. Client #3's record did not indicate documentation of client #3's written informed consent for the use of psychotropic medication for behavior management. Client #3's HRC form dated 9/15/14 indicated the facility's HRC had approved the use of client #3's psychotropic medication/Risperdal without the written informed consent of client #3.</p>		Staff, Operations Team	

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W000312	<p>4. Client #4's record was reviewed on 9/17/14 at 3:35 PM. Client #4's ISP dated 1/22/14 indicated client #4 had a legal guardian. Client #4's CMF dated 1/2014 indicated client #4 received Clonazepam (anxiety), Clonidine (ADHD), Divalproex (mood), Invega (bipolar) and Topiramate (mood). Client #4's 1/2014 CMF was not signed by client #4 or client #4's guardian. Client #4's BSP dated 9/1/14 indicated client #4 received Clonazepam, Clonidine, Divalproex, Invega and Topiramate for behavior management. Client #4's BSP dated 9/1/14 was not signed by client #4 or client #4's guardian. Client #4's record did not indicate documentation of client #4 or client #4's written informed consent for the use of psychotropic medications for behavior management.</p> <p>RM (Resident Manager) #1 was interviewed on 9/18/14 at 11:04 AM. RM #1 indicated psychotropic medication should have written informed consent of the client or client's guardian.</p> <p>9-3-4(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate</p>			

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	<p>behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 2 of 4 sampled clients (#1 and #2) on behavior controlling medications, the facility failed to ensure clients #1 and #2 had an active treatment program with a plan of reduction.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 9/17/14 at 3:59 PM. Client #1's POF (Physician Order Form) dated 8/6/14 indicated client #1 received Strattera 40 milligrams for ADHD (Attention Deficit Hyperactivity Disorder). Client #1's BSP (Behavior Support Plan) dated 8/1/14 did not indicate documentation of the use of Strattera 40 milligrams daily for behavior management. Client #1's record did not indicate documentation of an active treatment program with a plan of reduction for the use of Strattera 40 milligrams.</p> <p>2. Client #2's record was reviewed on 9/17/14 at 2:35 PM. Client #2's POF dated 8/1/14 indicated client #2 received Strattera 60 milligrams (ADHD) and Risperidone 1 milligram (ADHD). Client</p>	W000312	<p>CORRECTION:</p> <p><i>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Specifically for Clients #1 and #2 medication reduction goals will be included in their behavior support plans. A review of facility BSPs indicated this deficient practice also affected to additional clients #7 and #8. Medication reduction plans will be added to their BSPs as well.</i></p> <p>PERVENTION:</p> <p>The QIDP has been retrained regarding the need to incorporate goals to reduce and eventually eliminate the use of behavior controlling medications into support plans whenever such medications are prescribed. The Governing Body has added an additional layer of supervision at the facility to assist the QIDP with focusing on support plan development and monitoring,</p>	10/10/2014

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W000440	<p>#2's BSP dated 8/11/14 did not indicate documentation of the use of Strattera 60 milligrams daily for behavior management. Client #2's record did not indicate documentation of an active treatment program with a plan of reduction for the use of Strattera 60 milligrams.</p> <p>RM (Resident Manager) #1 was interviewed on 9/18/14 at 11:04 AM. RM #1 indicated psychotropic medication should be included in clients #1 and #2's active treatment program and include a plan of reduction.</p> <p>9-3-5(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) plus 4 additional clients (#5, #6, #7 and #8), the facility failed to conduct evacuation drills for each quarter on each shift of staff.</p> <p>Findings include:</p> <p>The facility's evacuation drill record was</p>	W000440	<p>including but not limited to assessing developmental and behavioral needs. Additionally, members of the Operations Team will review facility Behavior Support Plans no less than monthly and to assure plans for the reduction and eventual elimination of behavior controlling medications are included.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTION:</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel. Specifically, the facility has conducted additional evacuation drills on each shift during the current quarter.</p>	10/24/2014

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	<p>reviewed on 9/18/14 at 9:55 AM. The review indicated the facility failed to conduct an evacuation drill for 8 of 8 clients #1, #2, #3, #4, #5, #6, #7 and #8 for the first quarter, January, February and March 2014 for the day, evening and overnight shifts.</p> <p>CS (Clinical Supervisor) #2 was interviewed on 9/18/14 at 11:04 AM. CS #2 indicated evacuation drills should be completed once per quarter on each shift.</p> <p>9-3-7(a)</p>		<p>PREVENTION:</p> <p>Professional staff will be retrained regarding the need to conduct evacuation drills on each shift for all staff each quarter. The Operations Team will review all facility evacuation drill reports and follow up with professional staff as needed to assure drills occur as scheduled. Program Manager will track evacuation drill compliance and follow up with facility professional staff and the agency Safety Committee accordingly.</p> <p>RESPONSIBLE PARTIES:</p> <p>QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team</p> <p>CORRECTIONS COMPLETED BY:10/24/14</p>		