

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G673	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/10/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3521 OXFORD SOUTH BEND, IN 46615
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W 000 Bldg. 00	<p>This visit was for an investigation of complaints #IN00169194, IN00169949 and IN00169980.</p> <p>Complaint #IN00169194: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W157, W227 and W312.</p> <p>Complaint #IN00169949: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W153, W154, W157, W227 and W312.</p> <p>Complaint #IN00169980: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W153, W154, W157, W227 and W312.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: 3/31, 4/1, 4/2, 4/6, 4/7 and 4/10/15</p> <p>Facility Number: 009114 Provider Number: 15G673 AIM Number: 100244780</p>	W 000		
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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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W 102 Bldg. 00	<p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Governing Body for 3 of 4 sampled clients (A, B and D) and for 1 additional client (H). The governing body failed to ensure the facility replaced clients' mattresses which had bed bugs. The governing body failed to ensure its policy and procedures regarding bed bugs specifically addressed how the facility was going to treat the bed bugs to assist in eradicating the bed bugs to provide the clients a comfortable home free of bed bugs. The governing body failed to ensure the clients, who lived in the group home, were not abused and/or neglected (clients A and H) in regards to an overdose and a sexual assault. The governing body failed to ensure its outside day service provider supervised/monitored clients to prevent sexual abuse of client A, and to ensure all staff were trained in regard to the day program's corrective actions. The</p>	W 102	<p>All staff are trained upon hire, annually and on an as-needed basis on the policy and procedure concerning abuse, neglect, and exploitation. The Program Director/QIDP and all direct care staff at the home will be retrained on abuse, neglect and exploitation policy. As of 3/31/15 all staff were retrained on guidelines regarding one-on-one supervision, medication and medication key security and the implementation of a new medication key log form in an effort to prevent future incidents of this nature. In conjunction with the corrective action for W149, going forward, staff have been trained that the medication room door will be kept locked at all times staff are not present in the room as a further layer of protection. For the next six weeks, the Program Director/QIDP will conduct five weekly unannounced visits to the home on various shifts in order to ensure that staff are accurately implementing the medication and medication key security measures</p>	05/10/2015

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	<p>governing body failed to ensure the facility conducted thorough investigations in regard to an allegation of staff to client abuse, and reported bed bugs in the group home to state officials each time the bed bugs returned to different areas of the homes/different clients' bedrooms for clients A, B, D and H. The governing body failed to ensure recommended corrective actions were implemented once investigations were completed for clients A and H.</p> <p>Findings include:</p> <p>1. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for 3 of 4 sampled clients (A, B and D) and for 1 additional client (H). The governing body failed to implement its policy and procedures to prevent neglect of clients A and H in regard to a client overdosing himself on medication locked from the group home, and in regard to client to client sexual abuse. The governing body failed to report all allegations of abuse and/or neglect to state officials for clients A, B and D. The governing body failed to conduct a thorough investigation in regard to all reported allegations of abuse and/or neglect. The governing body failed to ensure recommended corrective actions and/or measures were put in place</p>		<p>as well as utilizing the medication key log form on every shift. During the observations, the Program Director/QIDP will offer immediate feedback to the staff members in an effort to coach the staff that are not following the medication security procedures and to ensure the staff understand what needs to be done to complete the expectations to ensure the safety of persons served in the home. The visits will be documented on a site visit log and the Area Director will review them on a weekly basis for quality assurance purposes. After six weeks, the visits will taper off once proficiency has been determined.</p> <p>The Area Director and the supervisor from Client A's day service are meeting on 5/4/15 to revise Client A's Safety Plan in order to ensure that clear and effective guidelines for day service staff supervision of Client A are established in order to ensure his safety while at the workshop. The IDT will approve the revised Safety Plan and Dungarvin will ensure that a new plan is in place and all staff at the day service are trained on the revised plan by 5/10/15. If the day service provider cannot show proof of the required training, Client A will attend alternative day services until documentation of staff training is provided.</p>	

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	<p>in a timely manner for clients A and H. Please see W122.</p> <p>2. The governing body failed to ensure the facility implemented its written policy and procedures to prevent neglect/abuse in regard to client H accessing his medications and overdosing which resulted in hospitalization, as the client had a history of suicide ideation/attempts. The governing body failed to ensure the facility implemented its written policy and procedures to prevent abuse/sexual assault of client A, at the day program, and to ensure recommendations and/or appropriate corrective actions were addressed/taken.</p> <p>The governing body failed to ensure the facility reported an allegation of abuse made during an abuse/neglect investigation regarding client H, and to report an allegation of possible neglect in regard to bed bugs at the group home which involved clients A, B and D. The governing body failed to ensure the facility conducted a thorough investigation in regard to the client's overdose and in regard to an additional allegation of abuse made by client H's mother.</p> <p>The governing body failed to ensure the facility implemented its recommended</p>		<p>Once the plan is in place, for six weeks and then until proficiency has been determined the Program Director/QIDP will complete three unannounced visits per week to the day service provider at various times in order to ensure that the day service is accurately implementing the plan. During the observations, the Program Director/QIDP will report any staff members who are not following the plan to the day service supervisor in order to ensure that staff understand what needs to be done to complete the expectations to ensure the safety of Client A while at day services. The visits will be documented on a day program observation form and the Area Director will review the observations on a weekly basis for quality assurance purposes.</p> <p>The Program Director/QIDP failed to include the additional allegation of abuse made by Client H's mother in the follow up report to the 3/17/15 incident involving Client H and/or failed to complete a separate IR for the additional allegation. However, this allegation was investigated and is included in the investigation into the 3/17/15 incident involving Client H.</p> <p>The Program Director/QIDP reported that bed bugs had been found in the home on 8/11/14.</p>		

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	<p>corrective actions/measures in regard to seeking counseling services for client A who was sexually assaulted. The governing body failed to ensure the facility implemented its corrective actions/measures in regard to retraining staff, who had been suspended, prior to returning to work in regard to an incident involving client H. The governing body failed to ensure the facility developed a specific policy or procedure in regard to addressing how the facility would get rid of bed bugs, and replace clients' mattresses as recommended. Please see W104.</p> <p>This federal tag relates to complaints #IN00169194, #IN00169980 and #IN00169949.</p> <p>9-3-1(a)</p>		<p>Since that time Dunganarvin has been treating the bed bugs in the home with professional extermination services and staff have been monitoring the bed bugs via a daily bed bug cleaning checklist. Plastic mattress covers were placed all mattresses and box springs in the home as a protective measure and persons served have been free from bed bug bites since the initial infestation on 8/11/14. The bed bugs have been managed since that time and several rounds of professional treatments have occurred, however the bed bugs have never been successfully eradicated from the home. No new infestation of the home occurred which required an additional IR nor was there an allegation or suspicion that neglect had occurred related to the bed bugs being present and/or the management or treatment.</p> <p>In conjunction with the corrective action for W153, W149, W122, and W104, the Program Director/QIDP will be retrained by 5/10/15 on the expectation that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown origin will be reported immediately to the administrator/Area Director and/or to state officials according to state law and established procedures. All agency staff, including Program</p>		

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			<p>Director/QIDPs and Area Directors, are retrained on this expectation during annual conditions of employment mandatory trainings.</p> <p>It is Dungarvin's intention to comply with the expectation that all allegations will be investigated thoroughly and in a timely fashion. We expect the Program Director/QIDP to keep a record of this investigation along with the incident and incident follow up as submitted to BQIS. This investigation is to include all related evidence, witness statements, a review of previous similar incidents and all pertinent information necessary to prove or disprove the allegation.</p> <p>In this case, the Program Director responsible for this ICF facility at the time of this incident completed a thorough investigation into the incident but based on the information that could be ascertained it could not be determined how Client H accessed his medications. All staff who worked in the home from the last time the medications were verified to have been present through to the time the overdose was discovered were suspended and interviewed. Attempts were also made to interview Client H and his mother, however both refused to be interviewed and refused to grant Dungarvin access to the hospital</p>	

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			<p>records for Client H related to the incident. The information which was provided to the surveyor by Client H's mother regarding the medications being out on a desk and staff failing to supervise Client H due to being in the "back living room watching television" was never provided to Dungarvin by Client H or his mother despite attempts to interview Client H and several conversations with his mother during the investigatory process. The information provided to the surveyor that staff were in the "back living room watching TV" is also not likely as there is no working television in the back living room at the home. Based on the scheduled and documented activities occurring during the timeframe of the incident on 3/17/15 it is also not likely that all 8 clients were in the home at the time that Client H accessed his medications as was further alleged to the surveyor. The allegations related to staff purposely overdosing Client H and the allegation that Client H had fallen and hit his head in the driveway were thoroughly investigated and were unsubstantiated as is documented in the investigation report into the incident.</p> <p>In conjunction with the corrective actions for W154, W149, W122, and W104, the Program Director/QIDP will be retrained by 5/10/15 on Dungarvin's</p>	

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			<p>expectations regarding how to thoroughly conduct investigations in an effort to continue to complete thorough investigations into all allegations of abuse/neglect/exploitation, injuries of unknown origin, and peer-to-peer aggression. All Program Director/QIDPs will report findings of the investigations to the administrator/Area Director within 5 business days and inform the Area Director of the progress of the investigation throughout the investigation process while it is being completed. The Area Director will provide ongoing feedback to the Program Director/QIDP to ensure a thorough investigation is being conducted. The Program Director/QIDPs will also maintain an annual file of all incident reports filed on behalf of each client in the home. The Program Director/QIDPs will submit an investigation summary to the Area Director and maintain copies of all related investigation documentation and attach as supplemental documentation to the original incident reports in the file. The Area Director will review investigations with the State Director and/or the Director of Human Resources in an effort to determine that a thorough investigation has been completed and the corrective action(s) are prudent.</p>	

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			<p>Staff were suspended pending the investigation into the 3/17/15 incident with Client H. Following the investigation staff were removed from suspension on 3/27/15 and were given the retraining recommended by the investigation over the phone prior to returning to work. On 3/31/15 all staff that were suspended completed a formal retraining as scheduled.</p> <p>Client A was referred to a local mental health facility for counseling related to the incident that occurred on 2/6/15, however he did not start counseling. In conjunction with the corrective action for W157, W149, W122, and W104, the Program Director/QIDP will follow up on the referral by 5/10/15 to ensure that Client A is scheduled for counseling to address issues related to the sexual assault that occurred and Client A's sexuality training needs.</p> <p>The Program Director/QIDP will be retrained by 5/10/15 that all staff returning to work following an investigation will receive formal, documented retraining as recommended in the investigation report. The Program Director/QIDP will also be retrained by 5/10/15 on the expectation that any corrective actions noted in an investigation report will be implemented as required and plans will be</p>	

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			<p>updated and all staff will be retrained per the recommendations to ensure the issue does not recur in the future. The Program Director/QIDP will send all investigation reports to the Area Director for review to ensure the investigation was thorough and the appropriate corrective measures have been outlined. The Area Director will monitor all incident reports filed externally to BQIS and all internal incident reports to ensure all issues requiring investigations have investigation reports completed.</p> <p>Dungarvin has a written procedure to address the issue of a bed bug infestation within a service site. The procedure includes a detailed treatment checklist which provides staff detailed directions on how to prepare the site for treatment prior to the exterminator's arrival as well as control measures for staff to follow after treatment to maximize the success of each treatment. From the time the bed bugs were initially identified as being present in the home until the present Dungarvin has ensured that treatments were scheduled and carried out as recommended by the pest control company. There have been several treatments of the home. Dungarvin will develop a written policy to address infestations at service sites; however until that</p>	

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			<p>policy is in place and approved the current bed bug treatment and monitoring procedures will remain in place. Since the time of the treatment on 4/1/15 neither bed bugs nor evidence of bed bugs or any other bugs has been found in the home. Direct Care staff, Maintenance staff and the Program Director and Area Director continue to monitor for signs of an active infestation. In conjunction with the corrective actions for W104, Should signs of an active infestation be found staff will be retrained on the daily bed bug management procedures and a treatment by the pest control company will be scheduled.</p> <p>Dungarvin has reviewed the regulations and the Indiana State FAQs for bed bug infestations and has not found that replacement of all mattresses in the home is a requirement nor is it identified as being an effective manner of eradicating bed bugs from a home. In conjunction with the corrective actions for W104, once the bed bugs are determined to have been eradicated by Dungarvin's maintenance coordinator Dungarvin plans to replace the mattresses of those individuals who had previously had bed bugs found in their rooms. In the meantime, mattresses and box springs for all beds in the home remain covered in plastic</p>	

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W 104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 3 of 4 sampled clients (A, B and D), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility replaced clients' mattresses which had bed bugs. The governing body failed to exercise general policy and operating direction over the facility to ensure its policy and procedures regarding bed bugs specifically addressed how the facility was going to treat the bed bugs to assist in eradicating the bed bugs to provide the clients a comfortable home free of bed bugs.</p> <p>Based on observation, interview and record review for 3 of 4 sampled clients</p>	W 104	<p>encasements and all beds and individuals who reside in rooms previously known to have bed bugs will continue to be checked on a daily basis for signs of bed bugs.</p> <p>System wide, all Program Director/QIDP's will review this condition and assure that this concern is being addressed at all Dungarvin ICF-ID's.</p> <p>Dungarvin has a written procedure to address the issue of a bed bug infestation within a service site. The procedure includes a detailed treatment checklist which provides staff detailed directions on how to prepare the site for treatment prior to the exterminator's arrival as well as control measures for staff to follow after treatment to maximize the success of each treatment. From the time the bed bugs were initially identified as being present in the home until the present Dungarvin has ensured that treatments were scheduled and carried out as recommended by the pest control company. There have been several treatments of the home. Dungarvin will develop a written</p>	05/10/2015

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	<p>(A, B and D) and for 1 additional client (H), the governing body failed to exercise general policy and operating direction over the facility to ensure the clients, who lived in the group home, were not abused/neglected in regard to a client's overdose and the sexual assault of a client. The governing body failed to exercise general policy and operating direction over the facility to ensure its outside day service provider supervised/monitored clients to prevent sexual abuse of a client, and to ensure all staff were trained in regard to the day program's corrective actions. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted thorough investigations in regard to an allegation of staff to client abuse, and reported bed bugs in the group home to state officials each time the bed bugs returned to different areas of the homes/different clients' bedrooms. The governing body failed to exercise general policy and operating direction over the facility to ensure recommended corrective actions were implemented once investigations were completed.</p> <p>Findings include:</p> <p>1. Interview with administrative staff #1</p>		<p>policy to address infestations at service sites; however until that policy is in place and approved the current bed bug treatment and monitoring procedures will remain in place. Since the time of the treatment on 4/1/15 neither bed bugs nor evidence of bed bugs or any other bugs has been found in the home. Direct Care staff, Maintenance staff and the Program Director and Area Director continue to monitor for signs of an active infestation. Should signs of an active infestation be found staff will be retrained on the daily bed bug management procedures and a treatment by the pest control company will be scheduled.</p> <p>Dungarvin has reviewed the regulations and the Indiana State FAQs for bed bug infestations and has not found that replacement of all mattresses in the home is a requirement nor is it identified as being an effective manner of eradicating bed bugs from a home. Once the bed bugs are determined to have been eradicated by Dungarvin's maintenance coordinator Dungarvin plans to replace the mattresses of those individuals who had previously had bed bugs found in their rooms. In the meantime, mattresses and box springs for all beds in the home remain covered in plastic encasements and all beds and individuals who reside in rooms</p>				

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	<p>and the Program Director (PD) on 3/31/15 at 1:25 PM indicated clients A, B, C, D, E, F and G would be going to a hotel to stay for one night. The PD indicated the clients would leave the group home at 8:00 AM on 4/1/15. When asked why, administrative staff stated "For the treatment of bugs." When asked if the group home had bed bugs, administrative staff #1 stated the group home was being treated for "all kinds of bugs, not just bed bug." Administrative staff #1 indicated the group was undergoing its second round of sprays/treatments for bed bugs. Administrative staff #1 and the PD indicated one bed bug was found on the bed of a different client last week. Administrative staff #1 stated "Now in second bedroom with bug casings. We decided to move everyone out to remove some paneling." Administrative staff #1 and the PD indicated the bed bugs were originally in client C's bedroom (front area of the group home) a few months ago but were not in the back bedrooms of the group home.</p> <p>During the 3/31/15 observation period between 5:55 PM and 7:20 PM, at the group home, there were 6 holes on the back living room walls, with plaster showing and/or missing plaster. One area on the wall had a 2 by 4 piece of</p>		<p>previously known to have bed bugs will continue to be checked on a daily basis for signs of bed bugs.</p> <p>In conjunction with the corrective action for W153, W149, and W122, the Program Director/QIDP will be retrained by 5/10/15 on the expectation that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown origin will be reported immediately to the administrator/Area Director and/or to state officials according to state law and established procedures. All agency staff, including Program Director/QIDPs and Area Directors, are retrained on this expectation during annual conditions of employment mandatory trainings.</p> <p>In conjunction with the corrective action for W154, W149, and W122, the Program Director/QIDP will be retrained by 5/10/15 on Dungarvin's expectations regarding how to thoroughly conduct investigations in an effort to continue to complete thorough investigations into all allegations of abuse/neglect/exploitation, injuries of unknown origin, and peer-to-peer aggression. All Program Director/QIDPs will report findings of the investigations to the administrator/Area Director within</p>	

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	<p>plywood covering the area. The hallway closet had tubs of clothes in 3 large plastic containers. One of the plastic containers did not have a lid on the container. Client A carried a load of clothes and his bed linens to the laundry room to wash. Facility staff did not assist/encourage the client to wash his clothes in hot water. The living room couches were covered with a sheet like material. During the observation period, facility staff did not sit down on any furniture in the group home, unless they were in the office area. Interview with client A on 3/31/15 at 6:00 PM indicated the facility removed the panels from the wall and were replacing the panels with drywall.</p> <p>During the 4/1/15 observation period between 5:41 AM and 7:20 AM, at the group home, client A was packing a bag to take with him to the hotel. Staff #1 and staff #7 wore gloves during the observation period when in the kitchen, cleaning and/or removing mattress covers from the back bedrooms of clients A, B and D. Staff #7 took the mattress covers outside. Clients A, B and D's clothes were bagged up in dark trash bags and placed on the back living room couch of the group home. Client B and D's bedroom had a missing wall, where paneling used to be with a plywood board</p>		<p>5 business days and inform the Area Director of the progress of the investigation throughout the investigation process while it is being completed. The Area Director will provide ongoing feedback to the Program Director/QIDP to ensure a thorough investigation is being conducted.</p> <p>In conjunction with the corrective action for W157, W0227, W149, and W122, the Program Director/QIDP will follow up on the referral by 5/10/15 to ensure that Client A is scheduled for counseling to address issues related to the sexual assault that occurred and Client A's sexuality training needs.</p> <p>System wide, all Program Director/QIDP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF-ID's.</p>	

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	<p>covering the hole in the wall. The plywood covered the length of the wall. Clients B and D's beds had wooden frames with wooden type floors made of vinyl. Carpet was in the living room, hallway and back living room.</p> <p>The facility's bed bug policy was reviewed on 3/31/15 at 2:42 PM. The facility's 12/3/10 Memorandum entitled Dealing With Bed Bug Outbreaks indicated "We've had a few situations already with bed bug infestation across the organization, and based on the prevalent concerns, they may not go away any time soon. We want to handle the situations consistently across the organization, so the purpose of this memo is to provide some guidance about dealing with infestations and document best practices from states who've already tackled this problem...." The facility's policy defined what beds bugs were, what they would do if an employee volunteered to tell the facility they had bed bugs, but would not reimburse staff for getting bed bugs. The policy explained how bed bugs spread, and what the facility would do to "minimize infestation." The policy indicated the following (not all inclusive):</p> <p>"-Have employees wear shoes with shallow or no treads and without laces.</p>			

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	<p>Disposable 'booties' may be used to cover shoes upon entering the home. When leaving the site, the employees should remove the disposable booties and place them in a plastic bag before discarding.</p> <ul style="list-style-type: none"> -Have employees wear pants without cuffs. -Upon entering the site, have staff persons examine the site for evidence of infestation. -Tell employees to bring in as little as possible into homes. Any items brought into a program should be placed on a wooden or metal surface, not an upholstered surface on floor. -Avoid contact with upholstered furniture. -Beware when using plug laptops which plug into electrical outlets that bed bugs seem to be attracted to the computer's heat and may hide in outlets. -Upon leaving the home inspect yourself and items carried in for evidence of bedbugs...." The facility's 2010 policy indicated a protocol staff were to use before and after a bed bug spray treatment which required the staff to remove all bed coverings, vacuuming, floors, furniture and curtains. The policy also indicated items were to be placed in plastic bags and clothes washed in hot water and dried on high heat. The policy indicated "Note: Infested upholstered furniture must be discarded. Bed bugs 			

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	<p>are often almost impossible to eradicate from upholstered furniture without numerous follow up treatments. If you choose to keep infested mattress and box springs, you must seal them in a high quality mattress/box spring encasement, immediately after the initial treatment process. Tape over encasement zippers with good quality tape. If you decide or it is suggested to replace the mattress and box spring, encasement should also be put on the new mattresses and box springs to protect against lingering pest infestation." The memorandum also included a Bed Bug Preparation for treatment checklist. The facility's policy/memorandum did not specifically indicate how the facility should get rid of the bed bugs to ensure the clients had a safe and comfortable home to live in.</p> <p>Interview with administrative staff #1 and the PD on 3/31/15 at 4:15 PM indicated the facility had a bed bug policy. When asked if the facility had reported the bed bugs at the group home, administrative staff #1 indicated the bed bugs were initially reported when client C had bed bugs in his room. The PD indicated he thought it was reported 7 months ago. Administrative staff #1 indicated she thought the bed bugs report had been more recent than 7 months. Administrative staff indicated the bed</p>			

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	<p>bugs had not been reported that were found last week which resulted in the paneling being removed and replaced with drywall.</p> <p>Interview with client E on 4/1/15 at 6:12 AM indicated his bedroom was located at the back of the house. Client E indicated he did not have bed bugs. Client E stated "I keep the ones who have bed bugs out of my room."</p> <p>Interview with client A on 4/1/15 at 10:15 AM indicated staff had seen a bed bug in his bedroom. Client A stated "Staff saw them. I don't know what they look like." Client A indicated he had the same mattress he had when he moved into the group home 3 years ago. Client A indicated his mattress had not been replaced. Client A stated "They just keep changing bed sheets not covering of mattress." Confidential interview N indicated clients A, B and D's bedrooms had bed bugs.</p> <p>Confidential interview N indicated the facility was going to spray the entire house on 4/1/15 and replace the paneling in the group home. Confidential interview N stated "More than 1 bed bug found in their rooms." Confidential interview N indicated the clients' clothes were kept in the closet.</p>						

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	<p>Confidential interview P stated the bed bugs had been in client C's bedroom but it had "been months." Confidential interview P stated "It was infested behind panels" with bed bugs. Confidential interview P indicated clients A, B and D had bed bugs in their bedrooms. Confidential interview P indicated all clients had mattress covers on their bed. Confidential interview P stated they would try to change the mattress covers of clients A, B and D's beds "every three days." Confidential interview P indicated bed bugs would be inside of the client's mattress covers on the clients' mattresses. Confidential interview P indicated the bed bugs started in client C's bedroom. Confidential interview P indicated clients' clothes were kept in the hall closet. Confidential interview P indicated client P thought clients A, B and D's mattresses had been changed.</p> <p>Interview with administrative staff #2 on 4/2/15 at 12:20 PM indicated the facility had a bed bug policy. Administrative staff #2 indicated the facility's policy did not indicate how the facility was to eliminate the bed bugs. Administrative staff #2 indicated the mattresses would be replaced.</p> <p>Interview with the maintenance director</p>				

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	<p>on 4/1/15 at 2:15 PM indicated the Oxford group home had problems with bed bugs. The maintenance director stated "We have been dealing with bed bugs for over a year." The maintenance director stated some clients had gotten a new mattress due to "being worn out" not due to the bed bugs. The maintenance director indicated clients A, B and D's mattresses had not been replaced and they need to be replaced. The maintenance man indicated he was aware the facility staff was changing the mattress covering on the bed. When asked what was being done to get rid of the bed bugs, the maintenance director stated "We are defogging two times a day and using ground spray today (4/1/15) and tomorrow (4/2/15)." The director indicated he had purchased a formula (Total Pest Control spray) hotels used. The maintenance director stated all the paneling in the home was being torn out as he could see "nesting" behind the panels. The maintenance director indicated he checked the home 2 days ago and he did not find any live bed bugs. The maintenance director indicated the facility would need to replace the carpet to prevent the bed bugs from returning. The maintenance director indicated the carpet was not going to be replaced at this time.</p>			

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	<p>2. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent neglect/abuse in regard to client H accessing his medications and overdosing which resulted in hospitalization, as the client had a history of suicide ideation/attempts. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent abuse/sexual assault of client A, at the day program, and to ensure recommendations and/or appropriate corrective actions were addressed/taken. Please see W149.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility reported an allegation of abuse made during an abuse/neglect investigation regarding client H, and to report an allegation of possible neglect in regard to bed bugs at the group home which involved clients A, B and D. Please see W153.</p> <p>4. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted a thorough investigation in</p>			

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W 120 Bldg. 00	<p>regard to the client's overdose and in regard to an additional allegation of abuse made by client H's mother. Please see W154.</p> <p>5. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its recommended corrective actions/measures in regard to seeking counseling services for client A who was sexually assaulted. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its corrective actions/measures in regard to retraining staff, who had been suspended, prior to returning to work in regard to an incident involving client H. Please see W157.</p> <p>This federal tag relates to complaints #IN00169194, #IN00169980 and #IN00169949.</p> <p>9-3-1(a)</p> <p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. Based on observation, interview and record review for 1 of 4 sampled clients</p>	W 120	In conjunction with the corrective actions for W122 and W149, the	05/10/2015

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	<p>(A), the facility failed to ensure its outside day program provider monitored/supervised its clients to prevent sexual assault of client A. The facility failed to ensure the day program provider trained all its staff (client A's supervisor) to ensure the recommended corrective actions were completed, and failed to ensure the day program's supervision policy clearly indicated how the day program would periodically supervise bathrooms, break rooms and clients arriving to and leaving the facility to ensure the protection of clients.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 3/31/15 at 2:10 PM. The facility's 2/6/15 reportable incident report indicated "[Client A] called the agency's supervisor on call on Friday February 6, 2015 to report that while using the bathroom at Day Program at (sic) one of his peers came from behind, lowered his pants and underwear, and sexually assaulted him. [Client A] informed the on call supervisor that he did not report this incident to his supervisor at day program because the individual who assaulted him was standing next to the supervisor. [Client A] claimed that when he got home after the incident, he excreted</p>		<p>Area Director and the supervisor from Client A's day service are meeting on 5/4/15 to revise Client A's Safety Plan in order to ensure that clear and effective guidelines for day service staff supervision of Client A are established in order to ensure his safety while at the workshop. This will include but will not be limited to periodic supervision of the bathrooms, break rooms, and clients arriving and leaving the workshop. The IDT will approve the revised Safety Plan and Dungarvin will ensure that a new plan is in place and all staff at the day service are trained on the revised plan by 5/10/15. If the day service provider cannot show proof of the required training, Client A will attend alternative day services until documentation of staff training is provided.</p> <p>Once the plan is in place, for six weeks and then until proficiency has been determined the Program Director/QIDP will complete three unannounced visits per week to the day service provider at various times in order to ensure that the day service is accurately implementing the plan. During the observations, the Program Director/QIDP will report any staff members who are not following the plan to the day service supervisor in order to ensure that staff understand what needs to be done to complete the expectations to ensure the safety</p>	

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	<p>blood from his anus and experienced some pain. [Client A] was immediately sent to the ER (emergency room) where he was checked and they found some tearing in the anal cavity. Police officers interviewed [client A] who gave them the name of the peer he accused of sexually assaulting him...."</p> <p>The facility's 2/13/15 follow-up report to the 2/6/15 incident indicated the following:</p> <p>"1) What safety measures are in place at the individual's workshop to ensure the individual's safety? [Client A] is currently not going to his day program while the organizations are working on policies to ensure his and other individuals' safety at day program...."</p> <p>The attached 2/13/15 Day Program Investigative Report indicated the day program became aware of the incident on 2/9/15 as the incident had occurred on 2/6/15 at their facility. The day program's investigation indicated "XX (perpetrator) reported that [client A] approached him and initiated the physical contact that the two of them had in the bathroom stall. XX reported [client A] was a willing participant. 1. [Client A] reported that XX approached him without his consent and that he was not a willing</p>		<p>of Client A while at day services. The visits will be documented on a day program observation form and the Area Director will review the observations on a weekly basis for quality assurance purposes.</p> <p>System wide, all Program Director/QIDP's will review this condition and assure that this concern is being addressed at all Dungarvin ICF-ID's.</p>				

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	<p>participant in the physical activity in the bathroom stall. XX appeared to be forthcoming in when describing the incident and providing details. [Client A's] account of the incident matched XX's in the physical contact description but that it was unwanted. [Client A's] answers became more vague when specific questions were posed to him regarding his responses to the incident, when his residential staff were notified, and why almost 5 hours passed before a staff person was notified. It is clear that something happened in the bathroom stall during the afternoon transport time and involved sexual contact. It is unclear as to whether both parties gave consent as it is [client A's] word against XX and XX's word against [client A]. There were no other known witnesses to this incident. As a result, it could not be determined if XX sexually assaulted [client A]. It could not be determined if [client A] consented to the physical interaction of a sexual nature with XX. Therefore, the allegation of sexual assault was unsubstantiated. 2. As both XX and [client A] have legal guardians, and per Adult Protective Services (APS); anyone with a legal guardian cannot give consent for any sexual act, regardless of functioning level, with consent without consent from the legal guardian; it appears that both individuals' rights were</p>			

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	<p>violated as neither could legally give consent for the sexual contact."</p> <p>The day program's undated witness statement by the day program's workshop supervisor #1 indicated "...There is no supervision in the bathrooms. [The name of the perpetrator] has made allegations about other individuals doing the same thing to him in the past...." The undated witness statement indicated "...11. Were you trained to go into the restroom with [client A]? No. We do however, have periodic checks of the bathrooms, but if they are working, like right now, when [name of perpetrator] is in group, he will see [client A] leaving his group going to the bathroom and follow him. None of the supervisors will notice that since they are from different groups and they may end up engaging inappropriate behaviors."</p> <p>An undated witness statement by the day program's Program Coordinator (PC) indicated "...We have a coverage protocol which requires supervisors to periodically check the bathrooms. There also should be no touching, hugging, kissing or any of that behavior on [name of day program's] property...Have you noticed any romantic and or threatening interactions between [name of perpetrator] and [client A] in the past</p>						

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	<p>especially recently? Not that I know of. [Name of perpetrator] likes exaggerating things. Recently he said that he and [client A] were going out, but as far as I know, that is not true...."</p> <p>The day program's 2/13/15 investigation indicated client A was interviewed 2 different times. The day program's investigation indicated "I (client A) went to the bathroom and I was going to my number 1 (urinate). I got into the stall and forgot to close the door, and was busy doing my business, when [name of perpetrator] walked in and pulled his pants and mine down and shove (sic) his penis in my back. Did you say anything when he did this?" No, I did not say anything at first, but [name of perpetrator] asked me if it hurt and I told him, 'Yes [name of perpetrator] it hurts.' When you said that, what did [name of perpetrator] say to you? He did not say anything, but pushed even harder, and it was very painful...." Client A indicated the sexual assault continued until the perpetrator was called for his transport.</p> <p>The day program's 2/13/15 investigation indicated the following Corrective Action the day program put in place (not all inclusive):</p> <p>"1. Per the Director of Employment</p>			

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	<p>Services, the process has already started in adding additional staff to the Employment Services department. This will aide (sic) in the prevention of inappropriate behavior in the workshop setting and provide more monitoring of clients in their work groups, in the bathroom and during break time in effort to provide productive, healthy and safe interactions.</p> <p>2. Per the Director of Employment Services, the break time, cafeteria and bathroom monitoring protocol and staff assignments will be reviewed and revised, as appropriate, to ensure all clients areas and venues are monitored consistently providing safe environments...4. It may be beneficial to review the current behavior support plans of both XX and [client A] to ensure staff are aware of the strategies to implement in effort to prevent displays of inappropriate sexual behavior and inappropriate physical contact for both [client A] and XX. Additional Information: On 2/23/15, [administrative staff #1], Director of Employment Services and this investigator/writer spoke to [name of Program Director-PD] of Dungarvin outlining a safety contract for both individuals in effort to prevent future incidents. In addition to the corrective actions noted above, each of</p>			

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	<p>the individuals will have a safety contract that includes the expectation of refraining from physical contact with anyone while at the workshop at [name of workshop]. Each individual will be assigned a different bathroom to use. They will continue to remain in separate groups and will not take the same breaks and lunch breaks. One will go to the first breaks and the other one the second breaks. Each will notify their supervisor when they are leaving the group (unless it is a scheduled break or lunch). When going to the bathroom they will notify their supervisor so that if they do not return within 3 minutes a check can be completed to ensure their safety. Upon arrival in the morning, they will go directly to their assigned group and remain in their group at the end of the day until their transportation arrives to pick them up. Training will be provided to all workshop staff on 2/25 and 2/26/2015. [Client A] will return to work on 2/27/2015."</p> <p>The facility's 2/13/15 Investigation Report indicated the incident happened around 3:00 PM on 2/6/15 when it was time for the clients to leave the workshop. The investigation also indicated "...These two individuals have in the past accused each other of calling each other, and [client A's] guardian has,</p>			

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	<p>on several instances, instructed the individuals to stop calling or interacting with each other for sexually (sic) reasons, and has also blocked [name of the perpetrator's] phone from calling [client A's] phone. Despite all these attempts by his guardian to stop any communication between the two individuals, [client A] continued calling [name of perpetrator] and would go to the extent of using 'collect calls' to get through to [name of perpetrator]. This incident was reported to the state and both Dungarvin and [name of workshop] initiated separate investigations into the matter...." The facility's investigation indicated the workshop's "...findings are inconclusive as the individuals are pointing fingers at each other concerning who initiated it..." The facility's investigation also indicated "...[Client A] also informed the PD on 2/13/15 that sometime in 2014 he and [name of perpetrator] had engaged in some sexual act at one of the [name of day program's] bathrooms and that before that nothing like that had happened. [Client A] also states that he does not like what [name of perpetrator] did to him and is afraid that this could happen again, but wants to go back to work...."</p> <p>The facility's 2/13/15 investigation indicated "...IV. Findings of Fact: Based on the witness statements, these</p>			

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	<p>individuals do have some relationship. [Client A's] mother and the Oxford team have on several occasions cautioned [client A] about calling or receiving calls from [name of perpetrator], who has made it clear that he wants a romantic relationship with [client A]. Also, in 2014, there was an incident at [name of workshop] when both individuals agreed that it was consensual. V. Conclusion Based on Facts: 1. [Client A] was assaulted by [name of perpetrator]. 2. The rules, protocols and policies regarding client protection in bathrooms at day program are not clear as the interviewed staff contraindicated (sic) each other. 3. These individuals just happen to be in different groups at work, not because they are being separated. VI. Actions...2. [Client A] will go over the updated [name of workshop] coverage policy and accept it before he goes back there for day program. 3. Please see [name of workshops'] (sic) plan of correction regarding this incident for measures that are to be taken at Day Programs to protect the individuals."</p> <p>The day program's undated Restroom Supervision Policy was reviewed on 3/31/15 at 5:00 PM. The policy indicated "This policy is applicable and must be followed for all clients on the workshop floor whose Behavior Plan indicates a</p>			
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	<p>plan and/or concern for inappropriate sexual behavior. It is for the safety of all clients on the floor that Training Supervisors follow the following procedure for each client identified by their Program Coordinator at all times.</p> <p>All clients whom have been identified will request the permission of their Training Supervisor to use the restroom, this includes requesting permission during lunch and breaks. Upon approval of their request the Training Supervisor will set the timer in their work station for 3 minutes. When the time has expired the training supervisor will notify a float and/or PA (program assistant) that they will be leaving the group to check the restroom. If upon arrival the client states that they need additional time in the restroom the Training Supervisor will return to the group and reset the timer for an additional 3 minutes and then return upon expiration of that time. This shall continue until the client has returned to their work station. If a situation arises which prevents the Training Supervisor from being able to check the restroom when necessary it is their responsibility to seek the assistance of other Training Supervisors, Program Assistants and/or Program Coordinators. If a client fails to request the permission of their Training Supervisor, this will be documented in</p>			

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	<p>their daily summary and their Program Coordinator will be notified. At that time, it is the responsibility of the Program Coordinator to meet with the client and reiterate and review the restroom policy." The day program's undated Restroom Supervision Policy failed to indicate how the day program/workshop staff were to periodically monitor the bathrooms to prevent incidents from occurring during breaks, arrival to and from the day program to ensure protection of the clients.</p> <p>During the 4/1/15 observation at the day program/workshop between 10:14 AM and 11:00 AM, client A was on break in the break room. Client A was walking down between lockers in the break room to the main break area. Client A returned to his work area and sat down at his work station. Upon arrival to his work area, a bell sounded and the clients in his area left to go to the break room. Client A was at his work station by himself. No supervisor was in the area. The bathroom client A was to use was across from the client's program area. Interview with client A on 4/1/15 at 10:16 AM indicated client A was on the first break and his group and the perpetrator's group were on the second break. Client A indicated the other client's work area was at the back of</p>			

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	<p>the workshop as his work area was near the front of the workshop. When asked how he was being monitored since no one was in his area, client A stated "[Day program supervisor #2] is watching me." When asked where was day program staff #2, client A pointed to an area behind us and to the side and stated "There." There was a partition/cabinets which prevented us from seeing day program supervisor #2 and the day program supervisor from seeing client A. Client A indicated his supervisor was at a meeting and day program supervisor #2 was to monitor/watch him. Client A indicated he would have to tell his supervisor if he needed to use the bathroom, and then he would have 3 minutes to use the bathroom. Client A stated if he did not return to his work area in 3 minutes, there would be a "page over the intercom."</p> <p>Client A's record was reviewed on 4/1/15 at 3:08 PM. Client A's 2/7/15 Emergency Department (ED) Discharge Instructions indicated "Diagnosis: Anal tear, Sexual assault." The ED discharge instructions indicated client A was given "patient Education" in regard to sexual assault and rape. The undated educational material indicated "...Sexual assault is called rape if penetration has occurred. Sexual assault and rape are never the victim's fault...." The undated education</p>			

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	<p>material indicated "An anal fissure is a small tear or crack in the skin around the opening of the butt (anus). Bleeding from the tear or crack usually stops on its own within a few minutes. The bleeding may happen every time you poop until the tear or crack heals...." The ED discharge instructions indicated labs and STD (sexually transmitted disease) tests had been ordered.</p> <p>Client A's 3/2/15 IDT (interdisciplinary team) note indicated "[Name of day program] has a safety contract to help [client A] stay safe...Mom is concerned that this was promised before and yet the incident happened. Mom is concerned that [name of perpetrator] continued working while [client A] stayed out of work for such a long time...." Client A's IDT note indicated the following (not all inclusive):</p> <p>"-There was no-one monitoring the guys when this happened. -[Name of day program] promises to have more staffing to monitor the individuals. -Mom is upset that [client A] had to go through this... -[Name of day program] will rearrange the work floor to make it easy for the supervisors to see what everyone is doing. It will be groups of 10.</p>			

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	<p>-[Client A] wants to get back to work... -[Client A] will have a different supervisor and will continue doing the same jobs that he was doing with supervisor [day program supervisor #2]. -[Client A] and [name of perpetrator] are no longer in close groups... -[Name of perpetrator] will have staff accompanying him to the bathroom. -[Client A] starts back to work on 3/3/15."</p> <p>An email from the day program and its training records were reviewed on 4/2/15 at 12:18 PM. The 3/2/15 email indicated "We have had another incident arise with [name of perpetrator]. That being said, effective immediately, [name of perpetrator] will be accompanied to the restroom every time...I understand that this is terribly inconvenient but for the safety of the clients, it is necessary. I will keep you posted on a long term solution but the above should be done in the meantime." Safety contracts signed by client A and the perpetrator were attached to the email. The Safety Contracts were signed on 3/2/15 by each client. Staff Developmental Training Records were also attached to the email. Review of the day programs training records indicated the facility trained their staff on 2/25/15. The training records indicated the day program staff were trained on client A's</p>			

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	<p>and the other client's "...Health and Safety Issues unique to the individual" which included the clients' safety contracts and the Restroom Supervision Policy. Review of the day program's training records indicated client A's current supervisor, day program supervisor #3, had not been trained. The facility failed to ensure all day program staff were trained in regard to client A's Safety Contract and Restroom Supervision Policy.</p> <p>An email received and reviewed on 4/2/15 at 1:22 PM indicated "[Day program supervisor #3] was not employed at the point of the training however she was trained by her Program Coordinator individually." The day program Director of Employment Services did not provide any additional documentation of the training.</p> <p>Interview with administrative staff #1 and the PD on 3/31/15 at 4:15 PM indicated client A was sexually assaulted while at his day program. Administrative staff #1 stated "Our investigation did not agree with theirs." Administrative staff #1 indicated the facility's investigation did determine client A was sexually assaulted/abused. Administrative staff #1 and the PD indicated client A was not allowed to return to the day program until</p>			

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	<p>safety measures were put in place.</p> <p>Administrative staff #1 indicated alternate day programs were offered to the client and his guardian, but the client and his guardian wanted to return to the same day program. Administrative staff #1 stated "She (client A's guardian) wanted to see if they could work it out." The PD indicated the day program sent an email the day program staff had been trained, but the facility did not have a copy of the training.</p> <p>Interview with client A on 4/1/15 at 10:16 AM indicated client A did not want the other client to perform the sex act. Client A indicated the perpetrator had not touched the client since the 2/6/15 incident occurred. Client A stated "I don't want to be his friend anymore."</p> <p>Interview with day program supervisor #3 on 4/1/15 at 10:43 AM indicated she recently became client A's supervisor. Day Program Supervisor #3 indicated client A would let her know when he wanted to leave the work area. When asked how client A was being monitored, day program supervisor #3 stated "His break schedule was switched. He uses the bathroom over there. He lets someone know when he moves around. He is very cooperative." Day program supervisor #3 indicated client A had not</p>			

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W 122 Bldg. 00	<p>had any additional problems.</p> <p>Interview with the PD on 4/2/15 at 12:20 PM stated "[client A] reported a client at the day program assaulted him." The PD indicated client A returned to the workshop on 3/3/15 after the day program put safety measures in place. The PD indicated there had been a history with the clients. The PD indicated since the 2/16/15 incident, client A had sent the other client text messages which the workshop noticed and shared with the facility. The PD stated the text messages were "not appropriate." The PD stated in a past incident, client A was the aggressor as the other client reported "[client A] attacked him." The PD indicated the other client ended up saying it was consensual. The PD indicated the day program's bathroom policy did not indicate how often day program staff were to monitor the day program bathrooms.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client</p>	W 122	All staff are trained upon hire, annually and on an as-needed basis on the policy and procedure	05/10/2015

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	<p>Protections for 3 of 4 sampled clients (A, B and D) and for 1 additional client H. The facility failed to implement its policy and procedures to prevent neglect of clients A and H in regard to a client overdosing himself on medication locked from the group home, and in regard to client to client sexual abuse. The facility failed to report all allegations of abuse and/or neglect to state officials for clients A, B and D. The facility failed to conduct a thorough investigation in regard to all reported allegations of abuse and/or neglect. The facility failed to ensure recommended corrective actions and/or measures were put in place in a timely manner for clients A and H.</p> <p>Findings include:</p> <p>1. The facility neglected to implement its written policy and procedures to prevent neglect/abuse in regard to client H accessing his medications and overdosing which resulted hospitalization, as the client had a history of suicide ideation/attempts. The facility neglected to implement its written policy and procedures to prevent abuse/sexual assault of client A, at the day program, and to ensure recommendations and/or appropriate corrective actions were addressed/taken. Please see W149.</p>		<p>concerning abuse, neglect, and exploitation. The Program Director/QIDP and all direct care staff at the home will be retrained on abuse, neglect and exploitation policy.</p> <p>As of 3/31/15 all staff were retrained on guidelines regarding one-on-one supervision, medication and medication key security and the implementation of a new medication key log form in an effort to prevent future incidents of this nature. In conjunction with the corrective action for W149, going forward, staff have been trained that the medication room door will be kept locked at all times staff are not present in the room as a further layer of protection. For the next six weeks, the Program Director/QIDP will conduct five weekly unannounced visits to the home on various shifts in order to ensure that staff are accurately implementing the medication and medication key security measures as well as utilizing the medication key log form on every shift. During the observations, the Program Director/QIDP will offer immediate feedback to the staff members in an effort to coach the staff that are not following the medication security procedures and to ensure the staff understand what needs to be done to complete the expectations to ensure the safety of persons served in the home.</p>		

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	<p>2. The facility failed to report an allegation of abuse made during an abuse/neglect investigation regarding client H, and to report an allegation of possible neglect in regard to bed bugs at the group home which involved clients A, B and D. Please see W153.</p> <p>4. The facility failed to conduct a thorough investigation in regard to the client's overdose and in regard to an additional allegation of abuse made by client H's mother. Please see W154.</p> <p>5 The facility failed to implement its recommended corrective actions/measures in regard to seeking counseling services for client A who was sexually assaulted. The facility failed to implement its corrective actions/measures in regard to retraining staff, who had been suspended, prior to returning to work in regard to an incident involving client H. Please see W157.</p> <p>This federal tag relates to complaints #IN00169194, #IN00169980 and #IN00169949.</p> <p>9-3-2(a)</p>		<p>The visits will be documented on a site visit log and the Area Director will review them on a weekly basis for quality assurance purposes. After six weeks, the visits will taper off once proficiency has been determined.</p> <p>The Area Director and the supervisor from Client A's day service are meeting on 5/4/15 to revise Client A's Safety Plan in order to ensure that clear and effective guidelines for day service staff supervision of Client A are established in order to ensure his safety while at the workshop. The IDT will approve the revised Safety Plan and Dungarvin will ensure that a new plan is in place and all staff at the day service are trained on the revised plan by 5/10/15. If the day service provider cannot show proof of the required training, Client A will attend alternative day services until documentation of staff training is provided.</p> <p>Once the plan is in place, for six weeks and then until proficiency has been determined the Program Director/QIDP will complete three unannounced visits per week to the day service provider at various times in order to ensure that the day service is accurately implementing the plan. During the observations, the Program Director/QIDP will report any staff members who are</p>		

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			<p>not following the plan to the day service supervisor in order to ensure that staff understand what needs to be done to complete the expectations to ensure the safety of Client A while at day services. The visits will be documented on a day program observation form and the Area Director will review the observations on a weekly basis for quality assurance purposes.</p> <p>The Program Director/QIDP failed to include the additional allegation of abuse made by Client H's mother in the follow up report to the 3/17/15 incident involving Client H and/or failed to complete a separate IR for the additional allegation. However, this allegation was investigated and is included in the investigation into the 3/17/15 incident involving Client H.</p> <p>The Program Director/QIDP reported that bed bugs had been found in the home on 8/11/14. Since that time Dungarvin has been treating the bed bugs in the home with professional extermination services and staff have been monitoring the bed bugs via a daily bed bug cleaning checklist. Plastic mattress covers were placed all mattresses and box springs in the home as a protective measure and persons served have been free from bed bug bites since the initial infestation on 8/11/14. The bed</p>	

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			<p>bugs have been managed since that time and several rounds of professional treatments have occurred, however the bed bugs have never been successfully eradicated from the home. No new infestation of the home occurred which required an additional IR nor was there an allegation or suspicion that neglect had occurred related to the bed bugs being present and/or the management or treatment.</p> <p>In conjunction with the corrective actions for W153, the Program Director/QIDP will be retrained by 5/10/15 on the expectation that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown origin will be reported immediately to the administrator/Area Director and/or to state officials according to state law and established procedures. All agency staff, including Program Director/QIDPs and Area Directors, are retrained on this expectation during annual conditions of employment mandatory trainings.</p> <p>It is Dungarvin's intention to comply with the expectation that all allegations will be investigated thoroughly and in a timely fashion. We expect the Program Director/QIDP to keep a record of this investigation along with the incident and incident follow up as</p>	

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			<p>submitted to BQIS. This investigation is to include all related evidence, witness statements, a review of previous similar incidents and all pertinent information necessary to prove or disprove the allegation.</p> <p>In this case, the Program Director responsible for this ICF facility at the time of this incident completed a thorough investigation into the incident but based on the information that could be ascertained it could not be determined how Client H accessed his medications. All staff who worked in the home from the last time the medications were verified to have been present through to the time the overdose was discovered were suspended and interviewed. Attempts were also made to interview Client H and his mother, however both refused to be interviewed and refused to grant Dungarvin access to the hospital records for Client H related to the incident. The information which was provided to the surveyor by Client H's mother regarding the medications being out on a desk and staff failing to supervise Client H due to being in the "back living room watching television" was never provided to Dungarvin by Client H or his mother despite attempts to interview Client H and several conversations with his mother during the investigatory process. The information</p>	

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			<p>provided to the surveyor that staff were in the "back living room watching TV" is also not likely as there is no working television in the back living room at the home. Based on the scheduled and documented activities occurring during the timeframe of the incident on 3/17/15 it is also not likely that all 8 clients were in the home at the time that Client H accessed his medications as was further alleged to the surveyor. The allegations related to staff purposely overdosing Client H and the allegation that Client H had fallen and hit his head in the driveway were thoroughly investigated and were unsubstantiated as is documented in the investigation report into the incident.</p> <p>In conjunction with the corrective actions for W154, the Program Director/QIDP will be retrained by 5/10/15 on Dungarvin's expectations regarding how to thoroughly conduct investigations in an effort to continue to complete thorough investigations into all allegations of abuse/neglect/exploitation, injuries of unknown origin, and peer-to-peer aggression. All Program Director/QIDPs will report findings of the investigations to the administrator/Area Director within 5 business days and inform the Area Director of the progress of the investigation throughout</p>	

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			<p>the investigation process while it is being completed. The Area Director will provide ongoing feedback to the Program Director/QIDP to ensure a thorough investigation is being conducted. The Program Director/QIDPs will also maintain an annual file of all incident reports filed on behalf of each client in the home. The Program Director/QIDPs will submit an investigation summary to the Area Director and maintain copies of all related investigation documentation and attach as supplemental documentation to the original incident reports in the file. The Area Director will review investigations with the State Director and/or the Director of Human Resources in an effort to determine that a thorough investigation has been completed and the corrective action(s) are prudent.</p> <p>Staff were suspended pending the investigation into the 3/17/15 incident with Client H. Following the investigation staff were removed from suspension on 3/27/15 and were given the retraining recommended by the investigation over the phone prior to returning to work. On 3/31/15 all staff that were suspended completed a formal retraining as scheduled.</p> <p>Client A was referred to a local mental health facility for</p>	

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			<p>counseling related to the incident that occurred on 2/6/15, however he did not start counseling. In conjunction with the corrective action for W157, the Program Director/QIDP will follow up on the referral by 5/10/15 to ensure that Client A is scheduled for counseling to address issues related to the sexual assault that occurred and Client A's sexuality training needs.</p> <p>The Program Director/QIDP will be retrained by 5/10/15 that all staff returning to work following an investigation will receive formal, documented retraining as recommended in the investigation report. The Program Director/QIDP will also be retrained by 5/10/15 on the expectation that any corrective actions noted in an investigation report will be implemented as required and plans will be updated and all staff will be retrained per the recommendations to ensure the issue does not recur in the future. The Program Director/QIDP will send all investigation reports to the Area Director for review to ensure the investigation was thorough and the appropriate corrective measures have been outlined. The Area Director will monitor all incident reports filed externally to BQIS and all internal incident reports to ensure all issues requiring investigations have investigation reports</p>	

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W 149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, interview and record review for 1 of 4 sampled clients (A) and for 1 additional client (H), the facility neglected to implement its written policy and procedures to prevent neglect/abuse in regard to client H accessing his medications and overdosing which resulted in hospitalization, as the client had a history of suicide ideation/attempts. The facility neglected to implement its written policy and procedures to prevent abuse/sexual assault of client A, at the day program, and to ensure recommendations and/or appropriate corrective actions were addressed/taken.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, facility Generated Event Reports (GER-internal incident reports) and/or investigations were reviewed on 3/31/15 at 2:10 PM and on 4/2/15 at 12:05 PM.</p>	W 149	<p>completed. System wide, all Program Director/QIDP's will review this condition and assure that this concern is being addressed at all Dungarvin ICF-ID's.</p> <p>All staff are trained upon hire, annually and on an as-needed basis on the policy and procedure concerning abuse, neglect, and exploitation. The Program Director/QIDP and all direct care staff at the home will be retrained on abuse, neglect and exploitation policy.</p> <p>As of 3/31/15 all staff were retrained on guidelines regarding one-on-one supervision, medication and medication key security and the implementation of a new medication key log form in an effort to prevent future incidents of this nature. Going forward, staff have been trained that the medication room door will be kept locked at all times staff are not present in the room as a further layer of protection. For the next six weeks, the Program Director/QIDP will conduct five weekly unannounced visits to the home on various shifts in order to ensure that staff are accurately implementing the medication and</p>	05/10/2015

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	<p>The facility's reportable incident reports, GERs and/or investigations indicated the following (not all inclusive):</p> <p>-1/13/15 "On 1/13/2015, [client H] came home from doctor's appointment and started pacing up and down near the kitchen. [Client H] is a new individual and was admitted to this house two weeks ago. [Client H] has a history of tantrums, emotional outbursts, property damage, physical aggression and self injurious behavior...." The 1/13/15 reportable incident report indicated [client H] retrieved a knife and made threats toward others in the group home and threatened to kill himself and his family as the client did not want to live at the group home. The 1/13/15 reportable incident report indicated "...Staff managed (sic) deescalate the [client H's] behavior and also told him to let go of the knife...." The reportable incident report indicated "...There is no need to be locking the knives at the mean time as it is not addressed in him behavior plan (sic). Staff is closely monitoring [client H's] behaviors and his health..."</p> <p>-3/7/15 "On Saturday, March 7, 2015 at about 2:04pm, staff reported that [client H] took a knife and attempted to cut himself on the neck and on the arm. Staff tried to calm him and asked him to put</p>		<p>medication key security measures as well as utilizing the medication key log form on every shift. During the observations, the Program Director/QIDP will offer immediate feedback to the staff members in an effort to coach the staff that are not following the medication security procedures and to ensure the staff understand what needs to be done to complete the expectations to ensure the safety of persons served in the home. The visits will be documented on a site visit log and the Area Director will review them on a weekly basis for quality assurance purposes. After six weeks the visits will taper off when proficiency has been determined.</p> <p>The Area Director and the supervisor from Client A's day service are meeting on 5/4/15 to revise Client A's Safety Plan in order to ensure that clear and effective guidelines for day service staff supervision of Client A are established in order to ensure his safety while at the workshop. The IDT will approve the revised Safety Plan and Dungarvin will ensure that a new plan is in place and all staff at the day service are trained on the revised plan by 5/10/15. If the day service provider cannot show proof of the required training, Client A will attend alternative day services until documentation of</p>		

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	<p>the knife down and he refused. At that point, [client H] threatened to harm everybody at the group home with the knife. Staff removed other individuals for safety and called 911. Staff followed protocol and informed the Program Director on call....Staff tried to deescalate and calm [client H] down but he threatened to harm himself and others. Staff called the police for safety. The police came to the group home and asked [client H] to drop the knife and he refused. Police then tasered him and cuffed him. Police transported [client H] to [name of hospital]. [Client H] was later admitted at [name of behavioral center] at around 6pm. The Program Director (PD) followed the police to [name of hospital] and later [name of behavioral center]. [Client H] is currently admitted at [name of behavioral center]. The team will continue to ensure [client H's] health and safety at all times."</p> <p>-3/17/15 "On 3/17/2015 while staff were getting ready to administer [client H's] medications, they discovered that his medications were missing from the med (medication) cabinet. Staff looked everywhere for the medications and could not find the meds. [Client H] has been known for throwing things in the trash can and they checked the trash can and found the meds in the trash can inside a</p>		<p>staff training is provided.</p> <p>Once the plan is in place, for six weeks and then until proficiency has been determined the Program Director/QIDP will complete three unannounced visits per week to the day service provider at various times in order to ensure that the day service is accurately implementing the plan. During the observations, the Program Director/QIDP will report any staff members who are not following the plan to the day service supervisor in order to ensure that staff understand what needs to be done to complete the expectations to ensure the safety of Client A while at day services. The visits will be documented on a day program observation form and the Area Director will review the observations on a weekly basis for quality assurance purposes.</p> <p>In conjunction with the corrective action for W153, the Program Director/QIDP will be retrained by 5/10/15 on the expectation that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown origin will be reported immediately to the administrator/Area Director and/or to state officials according to state law and established procedures. All agency staff, including Program Director/QIDPs and Area Directors, are retrained on this</p>	

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	<p>[name of store] plastic bag. There were some meds missing and when asked about it, [client H] told staff that he had taken his meds from the med cabinet earlier in the day. He also told staff that he took about 7 of the pills. Staff asked him what he had done with the other medications and he said that he had thrown them away. A few minutes later [client H] started showing signs that he was not doing well. His breathing changed and he started sweating. The emergency number was called and police and ambulances attended the scene. [Client H] was taken to the ER (emergency room) at [name of hospital] where he was admitted. [Client H] is still admitted and is listed as 'stable.' The agency suspended all the staff members who worked on this day at this site. Staff members are required to keep the medications locked in the med cabinet and never leave the med cabinet keys where individuals can take and use them...The agency policies require staff members to lock medications and ensure that no one has access to the meds except with staff. Staff members will be retrained and appropriate disciplinary action will be taken for those who did not follow company policy."</p> <p>The facility's 3/17/15 GER indicated staff #1 wrote the 3/17/15 GER. The 3/17/15</p>		<p>expectation during annual conditions of employment mandatory trainings.</p> <p>In conjunction with the corrective action for W154, The Program Director/QIDP will be retrained by 5/10/15 on Dungarvin's expectations regarding how to thoroughly conduct investigations in an effort to continue to complete thorough investigations into all allegations of abuse/neglect/exploitation, injuries of unknown origin, and peer-to-peer aggression. All Program Director/QIDPs will report findings of the investigations to the administrator/Area Director within 5 business days and inform the Area Director of the progress of the investigation throughout the investigation process while it is being completed. The Area Director will provide ongoing feedback to the Program Director/QIDP to ensure a thorough investigation is being conducted.</p> <p>In conjunction with the corrective action for W157 and W0227, the Program Director/QIDP will follow up on the referral by 5/10/15 to ensure that Client A is scheduled for counseling to address issues related to the sexual assault that occurred and Client A's sexuality training needs. System wide, all Program Director/QIDP's will review this</p>	

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	<p>GER indicated the incident occurred at 8:15 PM on 3/17/15. The GER indicated client H was sent out to the hospital around 9:00 PM. The GER indicated "[Client H] arrived home from accompanying staff for a transport of a house mate (sic) from an appointment to his home site. Staff noticed that [client H's] skin was flushed and he was sweating profusely. It was discovered that some of [client H's] medications were missing. [Client H] was asked if he took them and he remarked that he took seven pills. Shortly after this discovery [client H] started having slurred speech. The nurse and the program director on call were contacted and staff were directed to call [client H's] primary care physician. The after hours answering service was called and the doctor on call was paged. While waiting for the doctor to call, [client H's] symptoms worsened. He began to stagger and his slurred speech became worse. The nurse on call was contacted again and she directed staff to call 911. 911 was called and dispatched to the home site." The 3/17/15 GER indicated "...[Client H] took an overdose of his medications and experienced lethargy, slurred speech, pale skin and subsequent hospitalization...."</p> <p>The GER indicated client H was admitted to the hospital for observation. The GER indicated the PD reviewed the report on</p>		<p>standard and assure that this concern is being addressed at all Dungarvin ICF-ID's.</p>				

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	<p>3/24/15 at 11:46 AM. 3/17/15 GER indicated "[I (the PD) have reviewed this report] This is a 1:1 (line of sight) individual who should never be out of staff sight. That said, there is no acceptable explanation to how he had access to his medications. The med cabinet should always be locked and staff, and only staff members should have access to the medications. So between the 1:1 staff and the med passer always having the keys in (sic) their person, there is no reason why this individual should be doing this...."</p> <p>The facility's 3/24/15 follow-up report to the 3/17/15 incident "The investigation is still ongoing, but the individual served has been discharged from the hospital and from the agency by his mother. Staff will continue to ensure the safety of individuals by keeping their medications securely locked in the med cabinet."</p> <p>A second 3/24/15 follow-up report indicated the Bureau of Developmental Disabilities Services (BDDS-state reporting and licensure agency) indicated the state agency had the asked the following questions (not all inclusive):</p> <p>"1. Does the individual have a history of suicide ideation? On 3/72015, this individual had to be tasered by law</p>			

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	<p>enforcement personnel after threatening to cut himself with a knife. [Client H] had a knife in his hand and refused to listen to police when they asked him to drop it. He was tasered and later admitted to [name of behavioral center] for psychiatric evaluation.</p> <p>2. Did the individual intentionally take the wrong dose of medication? Based on the investigation that is still open, the individual intentionally took these medications.</p> <p>3. Was the individual aware of the consequences of taking the wrong dose of medication? It is unknown how much of this knowledge the individual retained, but each time during the med pass, he is being educated on the appropriate use of his medications.</p> <p>4. Please continue to provide updates on individual's mental/medical condition and hospitalization status. The individual was discharged from the hospital on 3/20/2015 and his mother took him and all his belongings home with her.</p> <p>5. What is the planned date of discharge? 3/20/2015</p> <p>6. What treatment was completed at the hospital? No information was provided</p>			

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	<p>about this since the individual's mother took him home with her. The individual has been discharged from Dungarvin services by his mother. The agency will continue requiring staff members to keep the medication locked and safe in the medication cabinet. Staff members were retrained on 3/20/15 on keeping medications safely stored."</p> <p>The facility's 3/27/15 Investigation Report indicated the facility's investigation was conducted from 3/17/15 to 3/24/15 by the Program Director. The facility's investigation indicated "I. History/Background: This report addresses allegations of abuse leveled against 6 staff members at the Oxford Group Home. On 3/1/15, evening staff members discovered individual [client H's] medications were missing. Staff searched the whole house looking for the medications and still could not find them. Staff decided to look for the medications in the trash cans as [client H] has thrown things in there before. Staff found the meds that were still bubble packs in the trash can, but there were about 25 pills missing from all the bubble packs that had been thrown out. [Client H] was asked about this and admitted that he took the medications sometime during the day and threw them in the trash. Asked about what happened</p>			

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	<p>to the medications that were no longer in the bubble packs, he told staff that he ingested 7 of them and threw away the rest. [Client H] started having slurred speech, looked tired and his skin was flushed and emergency medical assistance was sought for him, leading him to get admitted at [name of hospital] in [name of city]. Staff are trained to ensure that the med cabinet, where [client H's] meds are stored, is always locked and the meds secured in there. Staff are also trained to keep the med room door locked whenever there is no staff person in there. [Client H's] mother also alleged that staff [staff #5] purposefully gave [client H] an overdose of medications and that he (client H) had fainted on the day he took his meds and was left lying outside for 2 hours." The facility neglected to report the additional allegation of abuse made by client H's mother.</p> <p>The facility's 3/27/15 investigation indicated the facility was still interviewing staff on 3/25/15. The facility's investigation indicated staff #2, #3 and #4 worked during the day on 3/17/15. The facility's investigation indicated staff #4 was in the medication room during most of the day shift doing paperwork and checking the medications. The facility's investigation indicated staff</p>			

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	<p>#2, #3 and #4 indicated client H was not out of staff #2 and #3's sight during the day shift. Staff #2, #3 and #4 indicated the medications were kept locked. Staff #4's 3/17/15 and 3/18/15 witness statements indicated staff #4 came in at 7:20 AM on 3/17/15, indicated the staff cleaned up the group home and made beds until 9:00 AM when staff #4 went to assist client D to toilet and get him ready to leave for the day program. The staff's witness statement indicated staff #4 then went to the medication room to complete paperwork, review medications and labs until around 2:50 PM when staff #4 went grocery shopping. Staff #4's witness statement indicated staff #4 left the med room "about 5 or 6 times" during his shift. The staff's witness statement indicated client H only came in the medication room to ask for scissors to cut something out (staff #4 cut it out for him) and to get his medications. Staff #4's witness statement indicated staff #4 had the medication keys "for most of the day." Staff #4 indicated staff #3 also had the med keys as she was the medication passer for the day shift. Staff #4's witness statement also indicated client E had the medication keys during the day shift. Staff #4's witness statement indicated "...12. You said [client E]? [Client E just wanted something from the food cabinet and he gave the keys back to</p>			

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	<p>me (staff #4)...20. Does [client E] regularly get the keys to access the cabinet? Sometimes if he is preparing lunches for the next day he will be given the keys but staff will be standing there with him. He does not go in there by himself. Also he was not accessing the med cabinet, but there is a cabinet next to the med cabinet with snacks. Yesterday he was getting a snack for his lunch...." Staff #4's 3/25/15 witness statement indicated staff #7 also worked at the group home between 7 AM and 9 AM. The witness statement indicated "...when [staff #7] was at the house she followed him everywhere..." The facility's investigation indicated the facility failed to interview staff #7 as the staff had worked during the morning shift on 3/17/15.</p> <p>The facility's 3/17 to 3/24/15 investigation indicated staff #3 passed medications to client H at 10 AM, 12 PM and 2 PM. Staff #3's witness statement indicated "...I do not remember if I am the one who passed [client H's] 3pm meds because sometimes he gets mad when we change shifts)...Yes I had the keys in my pocket and when I passed meds I opened (medication cabinet). 8. Was the med cabinet locked each time you saw it? Yes, it was locked. We never leave it open. We take the</p>			

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	<p>meds, close it, and lock it. We do not leave the med room with the med cabinet unlocked...."</p> <p>The facility's 3/17 to 3/24/15 investigation indicated staff #1, #5 and #6 worked during the evening shift. The facility's investigation indicated staff #1 also worked from 6 AM to 10 AM on 3/17/15. The facility's investigation indicated the following staffs' witness statements (not all inclusive):</p> <p>-On 3/18/15 staff #1 indicated staff #1 worked from 6 AM to 10 AM and 2:07 PM to 10 PM on 3/17/15. Staff #1's witness statement indicated she was in the front of the house when she first came in while staff #3 did her documentation. Staff #1's statement indicated "...At 3:00 PM, other evening staff members came in. [Staff #6] came first and [staff #5] just after him. Staff [#2] returned with the [name of day program] guys that she had gone to pick up. The two morning staff went back and did their narratives, and I remained with staff [staff #5] in the front...Dinner was started early because we had to go grocery shopping and transport [client E's] class...." The witness statement indicated client H became upset when staff and clients were getting ready to leave "...about 5:40 PM. [Client H] had started to show some</p>				

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	<p>aggression as we were leaving. He was grabbing rocks outside and was pacing outside. So I left with the two individuals for shopping and for the other individual's class. We arrived home at just about 8:00 PM from shopping to unload groceries and pick [client E] up. [Staff #6] called me to the office, and said 'you passed meds this morning during your 6a-10p, where are [client H's] meds because there are non (sic) in his container?' I told him that I did not know where they went as they were there in the morning when I left. My first thought was since [staff #4] was home all day, he could have placed them somewhere differently. So we called him, and he said he did not know where the meds were and that he did not touch them. He asked me to look around and call him back. He also told me to call [staff #3] who had passed meds at 12. I did not call [staff #3] because I believe [staff #6] was going to call him (sic); it was time for me to go pick [client E] from the [name of police department]. When we left I was told that [client H] had been very cooperative, cleaning and taking out the trash assisting staff around the house. So when we had to go and pick [client E] up from [name of police department] we asked [client H] to go with us...[Client H] was in a good mood and talking to staff. He came into the house, [staff #6] asked</p>			

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	<p>me to come to the office. [Staff #6] said the meds were found in the trash can outside. [Client H] came behind me and said 'I did not steal my meds, don't accuse me of that.' I did not say anything, [staff #6] responded and said 'we are not accusing you of anything.' [Client H] went back and sat on the couch. [Staff #6] asked me to talk to him and find out if he had taken his meds or if he had ingested them. 2. Did you know at the time why he asked you to do this? Because he was assuming that he had ingested some of his meds. 3. What happened after that? I took him (client H) to the dining area where I could speak to him privately. I asked him to tell me the truth and he promised to tell me the truth. I asked him if he took his meds, and he said 'yes' and I asked him where he put the meds and he said in the trash can outside. I asked him if he ingested any of the meds and he said he had. I asked him how many he took, and he said 7. I asked him if he knew which ones he took, and he said he did not know. I asked him how and when he got the medications, and he said he got the medications when staff [staff #3] was there. I did not know what time that meant. He would not elaborate. When I asked him what he meant, he said he did not want to talk about it. 4. What did he look like at this point? His face was</p>			

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	<p>flushed, his eyes were red and he was sweating. I went and told the other staff what he told me, but according to the staff count, 25 meds were unaccounted for. [Staff #6] called the nurse, the nurse directed him to call his primary care doctor. [Staff #6] called after hours doctor on call and he got the answering service and they told him the doctor on call would call him as soon as possible. We were monitoring [client H] at this time and he was starting to get wobbly at this time and his speech was slurred, we called the nurse again and we were told to call 911. We called and they arrived in about 5 minutes, and the primary care doctor called at the same time and we told him 911 was already on site and he told us that that (sic) was exactly he was going to direct us to do (sic)...." Staff #1's witness statement indicated she followed the ambulance to the hospital. Staff #1's witness statement indicated no pills were found in the trash can with the bubble packs. Staff #1 indicated when she was in the home, the medication cabinet was locked and staff had the keys. Staff #1's witness statement indicated she did not have the keys during her shift. Staff #1's 3/19/15 witness statement indicated "...Staff members always follow [client H] especially when he tries to move to the back of the house because he goes out to</p>			

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	<p>pick stones up, or pulls the fire alarms. He may have stolen the meds sooner, but ingested them later after hiding them in his room for a while...it is hard to believe that he would have been able to do that because staff [staff #3] is very careful with the meds...."</p> <p>-On 3/18/15 staff #5 stated he was "assigned" to work with client H on the evening shift. Staff #5 indicated he did the transport to pick up other clients but client H stayed at home with staff #6 as client H was outside standing by the trash can with staff #6 monitoring the client from the front door. Staff #5 indicated when he returned, staff #1 was leaving to go shopping with 2 other clients. Staff #5's witness statement indicated client H wanted to go with them, but had not told staff #1 he wanted to go. Staff #5 indicated he told client H he would take him out once staff #1 returned to the group home as staff #1 could not watch the three of them. Staff #5 indicated client H then went back into the house and started cleaning up the kitchen and took a nap. The staff's witness statement indicated "...3. Does he take naps during our shifts? Once in a while, but yesterday was the first time he had asked to take a nap in about two weeks. I went inside his room to check him, and I realized that he had his suitcase packed</p>			

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	<p>and for his trip home...He slept for about 30 minutes, because I checked him, and I realized that he followed me. He then went outside and was walking by the stones, trying to collect, but I was with him and asked him to come back inside since it was a little cold. He was outside with me for about 45 minutes. He went back inside at about 8pm, and he went out there to assist carry the groceries (sic). I then asked [staff #1] if they were going to pick [client E] up, and she agreed to take him. It was at this time that staff [staff #6] said that [client H] needed to take his meds before going out since it was his med time. That was when the meds were discovered missing...After we discovered the meds missing, [client H] looked uncomfortable and his anxiety levels went up. Staff took him and [client A] out for transport. After they left, I went to check his packed bag to see if he packed the meds, and they were not there. Then we checked Therap (computer system) to see if they had been given before, and we saw that staff [staff #3] had passed them. We then took a torch and went outside. We checked the trash cans; we checked the trash cans because I remembered that when [client E's] wallet went missing [client H] had thrown it in the trans (sic) can. I opened the trash cans, at the top there were those big black trash bags.</p>			
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	<p>When I lifted the first one, under it, on top of another one, there was a [name of store] paper bag with the medications inside...After I clocked out, [client H] told me that he took the meds and that he trashed the other ones. I asked him when he did this, and he said it was during the day. I asked him if he remembered the meds that he had taken and he said he did not know...." Staff #5 indicated the med cabinet was kept locked and that staff #6 had the keys on his wrist. Staff #5 indicated he did not see client H fall and/or have a seizure. Staff #5's 2/25/15 second interview indicated "...2. What did you do with [client H] all day? Please note that I (staff #8) had other clients to deal with since we had all 8 guys at the house...5. Did staff follow every time or was he alone? The only time I did not follow him was when he was in his room napping, when he went to [name of police station] to pick [client E] up, and when I was on transport. The rest I always had my eyes on him...12. Why does he have 1-on-1 staff? I will say that [client H] had most of staff time not 100% 1:1. We get assigned more than one individual at the site and he was my individual for that day and I was following him everywhere. There were times when I would do other duties I was scheduled to do on that day, for example, I helped [client C] with his shower and</p>				

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	<p>when I did this, [staff #6] watched him. Each time I stepped aside, I would have [staff #6] watching him...."</p> <p>-On 3/18/15, staff #6 indicated client H was watching TV in the living room when staff #6 came in to work. Staff #6 indicated client H "... went out of the house to where the trash cans are and started collecting stones." Staff #6's witness statement indicated staff #6 followed the client outside where the client picked up stones and paced back and forth between staff's car and the trash cans until staff #1 came to the door to check on him and he followed staff #1 in the house. Staff #6's witness statement indicated client H picked up the house phone and looked at a list of posted phone numbers in the living room area, and then started writing on a piece of paper and pen he had gotten out of a kitchen drawer. The witness statement indicated client H ran towards a staff person to protect her when another client (client D) ran towards the staff. Staff #6 indicated staff #6 told client H "...not to touch the housemate or yell at him. I told him that staff would redirect the housemate. He did not like that and walked out of the house through the front door and went to his previous spot between my car and the trash cans and later started picking stones again...." The</p>			

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	witness statement indicated staff #5 followed the client outside until client H returned to the house and started cleaning. Staff #6's witness statement indicated client H then sat on the living room for 10 minutes before going to his bedroom to take a nap. Staff #6 indicated it was at the 8 PM medication pass where the client's meds were discovered missing. Staff #6 indicated they looked in other clients' med containers and "...We checked the whole med closet and we did not find the meds anywhere. So by that time I had them leave to go and pick [client E] and when they left I searched the whole med office (sic). I still didn't find them. Then [staff #5] told me that when he was in [client H's] room, he had noticed that his bag was packed and ready for him to visit his mother so he went and looked for the meds in there and they were not in there. Then he decided to check the trash cans inside the house and they were not there, but when he checked those outside the house, he found the meds in one of the trash cans in a [name of store] shopping bag. We checked the bag and all of his bubble packs were there. We were wondering if we needed to pass the meds since we found them in the trash. That was when we discovered that some pills were missing...when we further investigated we realized that there were			

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	<p>25 popped and not signed for...." Staff #6's witness statement indicated he did not see client H fall on the concrete, and client H did not complain about falling.</p> <p>The facility's 3/17/15 to 3/24/15 investigation indicated "...On 3/20/15, the social worker at [name of hospital] reported that [client H] told him that he broke into the medicine cabinet to take his medications. On the same day when asked by this PD, [client H] said more than once he did not know how he got his medications...."</p> <p>The facility's 3/17 to 3/24/15 investigation indicated the following:</p> <p>"a. The med cabinet was left unlocked sometime after 12pm on 3/17/15. While none of the staff persons at Oxford remember when [client H] was out of sight, it is clear that the individual was alone for some time and that was the time that he took the medications from the med room to another location. It is possible that when he took the medications from the med room, he hid them somewhere for a while and ingested them later. It is also possible that he took the medications, ingested them and stashed them in the trash can.</p> <p>b. [Client H] broke into the med cabinet</p>			

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	<p>to take the meds out. There is no sign that the med cabinet was broken into. The lock to the med cabinet is still intact and the key locks the cabinet when engaged.</p> <p>c. [Staff #5] Overdosed [client H]. Staff [staff #5] says he never passed anyone's medications on this day...</p> <p>d. [Client H] was left unconscious outside of the house for 2 hours. Staff stated that there was no time when [client H] was left unmonitored except the time when he napped for a few minutes Staff stated also that [client H] was never unconscious, and did not fall at all that day. [Client H] helped carry the groceries into the house, cleaned the kitchen and the dining room area sometime after dinner, [client H] also went with staff to pick a housemate from the [name of police department.].</p> <p>5. Staff delayed getting advanced medical assistance for [client H]. (His mother claims that [client H] was only taken in at 11pm). [Client H] started showing signs of not feeling well after coming back from picking up housemate from the came of [police department]. [Client H was back at the house around 9:15 PM and 911 was called a few moments after getting to the house when</p>			

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	<p>it was confirmed that he had taken the meds...."</p> <p>The facility's 3/17/15 to 3/25/15 investigation indicated "It is unclear when [client H] could have had access to his medications, when he took them out of the med cabinet, when and how many pills he ingested.. In order for [client H] to have access the medications, he would have accessed the keys if they were left somewhere unattended, he would have taken the meds after his last med pass before staff discovered they were missing or he would have climbed on a chair or desk to push his med tray down and had to pull the bubble packs one by one from the bottom of the medication cabinet. Staff members who had access to the keys on that day are: [staff #6] and [staff #3] who were the med passers and [staff #2] and [staff #5] who went to the food cabinet, and [staff #4] the med person who went into the med cabinet to check on the meds during the morning shift...The staff statements seem to provide a consistent story, the only thing against all this is the fact that [client H] was able to access his medications. V. Conclusion Based on Facts:</p> <p>a. [Client H] had access to his medications when no one was watching him.</p> <p>b. [Client H] also ingested some of his</p>			

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	<p>medications.</p> <p>VI. Actions</p> <p>a. Re-instate staff.</p> <p>b. Staff training on locking the med cabinet whenever they are not using it.</p> <p>c. '1:1 staffing' training for staff." The facility's 3/14 to 3/24/15 investigation indicated the facility completed the investigation on 3/27/15 as the PD signed the investigation on 3/27/15.</p> <p>The facility's 3/14 to 3/24/15 investigation indicated the facility neglected to interview all facility staff who worked with the client to determine which clients could access the medication keys to get into the snack cabinet, to see if staff laid the keys down, and/or left the medication cabinet unlocked/medication room door open. The facility neglected to interview clients to see if they witnessed anything in regard to medications and/or the keys on 3/17/15. The facility also failed to look at/describe the lay out of the house/environment during the investigation to determine how client H could get passed staff to access the medication room. The facility neglected to obtain/include an actual interview with client H, client H's mother and/or obtain client H's hospital records in regard to the incident.</p>			
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	<p>During the 3/31/15 observation period between 5:55 PM and 7:20 PM, at the group home, staff #1, #5 and #6, who had been suspended, were working with clients A, B, C, D, E, F and G.</p> <p>During the 4/1/15 observation period between 5:41 AM and 7:20 AM, at the group home, there was one staff (staff #8) working at the group home at 5:41 AM. Staff #8 was assisting client G to shower. The office door was unlocked and open. The medication cabinet was locked. Client B was walking around the house and down the hallway back and forth where the medication door was open. Client E was packing a bag and carried it to the front of the house. When staff #1 arrived at the group home at 6:50 AM, the medication room door was still open. At 6:53 AM, client E went in the kitchen and retrieved a set of keys out of the drawer and went outside to the van as staff #1 went to the front door. Client E unlocked the van and placed a small overnight bag into the van. Client E then brought the set of keys back in the house and placed the keys in the kitchen drawer. The key ring had more than the van keys on the key ring. At 6:02 AM, staff #1 closed the medication room door but did not lock the door as staff #8 had the key. At 6:05 AM, staff #1 obtained the keys from staff #8 and locked the</p>			

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	<p>office/med room door. Interview with client E on 4/1/15 at 6:12 AM indicated he knew the van key was on the ring, but he was not sure what the other keys were for.</p> <p>Client H's hospital records were reviewed on 4/1/15 at 8:45 AM. Client H's 3/17/15 Fire Department Patient Care Record (FDPCR) indicated the ambulance and emergency personnel arrived at the group home on 3/17/15 at 10:07 PM. The FDPCR indicated the chief complaint was "possible overdose." The FDPCR indicated client H's blood pressure was 103/80, pulse was 110, respirations were 16, blood glucose 118 and the client's oxygen level was 96. An electrocardiogram (ECG) (records electrical activity of the heart) lead was placed on the client at 10:13 PM. The FDPCR indicated "Comments sinus tach (tachycardia-faster than normal heart rate); Patient response: Unchanged." The 3/17/15 FDPCR indicated "Dispatched to a male with possible overdose. Upon arrival PD and staff are on scene at a group home for developmentally challenged individuals. Staff on scene reports that the patient had taken approximately 25 cephalexin (antibiotic), pramipexole (Depression/Bipolar Disorder), and quetiapine (Bipolar</p>			

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	<p>Disorder-Depression). Staff is unsure on the amounts of each pill. Staff also reports that the patient could possibly have taken them anytime from 1500-2100 (3 PM to 9 PM) this evening, they are unsure, but noticed that the patient was extremely angry when they came on shift around 1500 (3 PM). Staff reports a history of seizures and behavioral issues. According to engine 3 crew, patient has a violent past and has confronted the fire department before as well. Patient agrees to go to the hospital. Patient is secured to the cot and taken to the ambulance where vitals are obtained. Patient is placed on the monitor. Patient does not want an IV (intravenous) started, but agrees to have a bs (blood sugar) reading done...Patient answers all questions appropriately and remains alert throughout...."</p> <p>Client H's 3/17/15 Emergency Room (ER) Progress Note indicated client H arrived at the hospital at 10:33 PM. The ER progress note indicated when client H arrived to the ER his vital signs indicated his Pulse rate was 97, respirations were 14 and his blood pressure 104/62 (bottom number low). Client H's 3/17/15 Emergency/Urgent Care/Progress indicated client H "Got into medication and took an uncertain amount." The ER progress note indicated "...Pt (patient) brought in by fire department. Reported</p>			

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	<p>by medics the pt took a total of 25 pills in a combination of Seroquel, Keflex and pramipexole. Pt is lethargic...Pt care giver, by the last name of [staff #1] is at the bedside and states that the pt is high functioning and normally energetic and that this is not his baseline." Client H's ER progress note, at 1:27 PM, indicated "Pt instructed that we need a urine specimen. Pt is lethargic and opens eyes then closes them...pt stood at bedside to try and provide a UA (urine), pt unable to do so at this time, pt continueing (sic) to be drowsy, pt did stand with 1 assist."</p> <p>Client H's 3/17/15 ER/Urgent care note under Medical Decision Making indicated "...patient presents to ED (emergency department) via EMS (emergency medical services) after taking unknown amount of medication. Patient possibly took 8 pills of 500 mg (milligram) Keflex, 1 0.5 mg dose of Mirapex, 13 400 mg Seroquel doses, and 3 300 mg doses of Seroquel as these were missing from his normal medication supply...Patient appears mildly sedated but is able to follow commands and respond to questions. To assess possible overdose, I will order a drug screen, alcohol level, and a salicylate (chemicals found naturally in plants/aspirin) level. Will also order an EKG (also known ECG) to r/o (rule out) arrhythmia/QRS</p>			

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	<p>(/improper beating of the heart/problems with the heart)...Finally a CMP (comprehensive metabolic panel) ordered to assess any hepatic or renal insufficiencies...." The 3/17/15 ER note indicated the hospital contacted poison control and they recommended the client be admitted for overnight monitoring. The ER note indicated "...Patient was found outside by garbage. Caregiver states that patient's current condition is below normal functioning baseline...."</p> <p>Client H's 3/17/15 History and Physical (H & P) indicated "...The patient is said to have had suicidal ideation for a long time. He has been attempting suicide recently. Recently, he wanted to cut his throat with a knife and was tazed (sic) by the police, sent to [name of behavioral center] for about 36 hours and discharged. Then he overdosed on his medications. He was said to have stolen many pills of Seroquel, Mirapex and Keflex. It is unclear whether he swallowed these pills. The patient has cognitive deficits and is not able to give details of the history...." The H & P indicated "...He is drowsy, easily arousable. He is not completely oriented. He is able to ambulate. No focal neurological deficits...Suicidal attempt...." The H & P indicated "...Most of his information is obtained from the</p>						

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	<p>ER record and from the group home nurse...According to the group home nurse, the patient has been having suicidal ideations for approximately 1 year...." The H & P also indicated "...In the emergency room, laboratory workup (sic) was unremarkable except for elevated liver enzymes, ALT (alanine transaminase-enzyme found in the liver) of 104 and AST (aminotransferase-to determine liver damage) of 63...The patient was placed in observation status for probable medication overdose...."</p> <p>Client H's 3/20/15 Discharge Summary indicated client H's discharge diagnoses included, but were not limited to, "1. Drug Overdose. 2. Suicidal intent. Other Problems: 1. Developmental delay. 2. Cognitive deficits. 3. Depression." The client's discharge summary indicated "...He was sent from the group home because on the day of presentation, he had swallowed a lot of pills in a suicide attempt, mostly Seroquel and Mirapex. The patient is known to have attempted suicide a couple of times in the past, even recently with a knife...Following this hospitalization, his vital signs are within normal limits. He was drowsy on the day of discharge. Otherwise exam was not remarkable...." Client H's 3/20/15 discharge summary indicated client H did not want to return to the group home, but</p>			

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	<p>wanted to go home with his mother. The discharge summary indicated Adult Protective Services (APS) attempted to obtain an order from a judge to prevent the client from going home with the mother. The discharge summary indicated "...but they (APS) were not successful. The patient was very clear that he wanted to go home with his mother and he was not going to commit suicide so he was discharged in stable condition."</p> <p>Client H's record was reviewed on 4/1/15 at 1:58 PM. Client H's record indicated the following pre-admission paperwork:</p> <p>-12/30/14 Fax from an Outpatient Behavioral Health note which indicated a list of client H's current medications (Ativan-anxiety, Pramipexole-Depression, Quetiapine-Depression/Bipolar Disorder) and a summary of the client's hospitalization. The note indicated client H was hospitalized due to a "Mood problem." The 12/30/14 note also indicated "...You will be transported home per your mother with all your personal belongings. A person from Dunn Garvin (sic) will pick you up tomorrow to transport you to the group home. If you begin to have thoughts of hurting yourself and/or thoughts of</p>			

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	<p>hurting others please call 911 or report to your nearest emergency room."</p> <p>-12/22/14 History note indicated client H had a diagnosis of Suicidal Ideation as of 5/30/14 to the present and a diagnosis of Major Depression as of 9/27/14 to the present.</p> <p>-1/18/14 Individual Support Plan (ISP) from when client H lived at home with his mother, indicated client H's diagnoses included, but were not limited to, Pervasive Developmental Disorder, Bipolar Disorder, Obsessive Compulsive Disorder and Autism. Client H's record neglected to indicate and/or include any additional pre-admission information on the client.</p> <p>Client H's 12/30/14 Comprehensive Safety Assessment indicated "...Self Injurious Behavior N (no) Suicide Ideation N...."</p> <p>Client H's 1/23/15 initial Psychiatric Consultation indicated "This is [client H's] first appointment with [name of psychiatrist]. [Client H] has been having some behavioral difficulties, and his main complaint is that he wants to go back and live with his mother. [Client H] gets really angry when he calls his mother and she does not pick the phone and this</p>			

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	<p>usually starts other behaviors for him (sic)." The 1/23/15 consultation form indicated client H received the following behavioral/psychiatric medications:</p> <p>-Escitalopram 20 mg daily for Depression and Obsessive Compulsive Disorder...."</p> <p>-Quetiapine (Seroquel) 300 mg daily at bedtime for Bipolar Disorder.</p> <p>Client H's undated Behavioral Intervention Plan (BIP) indicated client H demonstrated the following targeted behaviors:</p> <p>-Anger Response -Physical Aggression -Verbal Aggression -Property Mishandling/Destruction.</p> <p>Client H's 1/2/15 Individual Support Plan (ISP) indicated "[Client H] moved into the Dungarvin Oxford Group Home on 01/02/2015. [Client H] is diagnosed with Mild mental retardation, epilepsy, pervasive developmental disorder, bi-polar disorder, obsessive compulsive disorder and autism...." Client H's 1/2/15 ISP indicated "...[Client H] has also informed staff on several occasions that he does not think moving into the group home was a good idea and wants to go back home...." The</p>			

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	<p>1/2/15 ISP also indicated "...[Client H] is to be monitored all the times as he will go and destroy property around the house without staff members noticing. Staff members need to have [client H] in their line of sight every time, at the house or in the community...."</p> <p>Client H's undated Interdisciplinary Team Meeting (IDT) (hand written notes) indicated the client's IDT met to discuss client H's 3/7/15 knife incident. The undated IDT note indicated the following (not all inclusive):</p> <p>"-...Staff couldn't do DCI (restraint technique) because he had a weapon. -Staff members were asked to move away by the police. -Its never been an issue. -Mom- he pulled a knife before & staff called me- Why not now? -HRC (Human Rights Committee) approved to lock sharps. -Nothing in BIP or high risk plan about informing the police about the VNS (Vagal Nerve Stimulator) and any kind of interaction... -Mom -he won't stop until he gets what he wants. -BDDS concern that he was hospitalized so many times & APS got involved. How are things going to be different this time.</p>			

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	<p>-Mom- I want what is best for him, but I don't want him tasered...</p> <p>-[Client H's] mom has arrangements made-[Client H] will live in his sister's basement.</p> <p>-[Client H's] family lives near a police station, when he gets angry he would walk to the PD (police department) & tell them he wanted to kill himself & they would take him to [name of hospital].</p> <p>-Mom claims between her & other family members, [client H] will have round the clock care...."</p> <p>Client H's undated BIP, ISP and/or undated IDT note indicated the facility neglected to clearly define/address client H's Depression/Bipolar Disorder and/or address client H's suicide attempts/suicide ideations. Client H's BIP, ISP and/or IDT note indicated the facility neglected to indicate how client H was to be supervised/monitored in regard to the client's suicide attempts/threats to harm self.</p> <p>The facility's inservice records were reviewed on 3/31/15 at 5:22 PM. The facility's 3/20/15 Statement Of In-Service Training For Employees indicated 7 staff were trained in regard to Med Administration, med administration policy and "Med Key Security." The 3/20/15 inservice record indicated staff</p>			

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	<p>#1, #2, #3, #4, #5 and/or #6, who had been suspended, had not been retrained. The facility neglected to retrain staff #1, #2, #3, #4, #5 and #6 as recommended.</p> <p>The facility's Key Form was reviewed on 3/31/15 at 6:45 PM. The March 19, 2015 Key Form indicated "STAFF SIGNATURE INDICATES THE STAFF MEMBER ASSUMES RESPONSIBILITY FOR THE MEDICATION ROOM, HIIPA (SIC) RECORDS, AND INDIVIDUAL'S (SIC) MEDICATIONS WITHIN THE ROOM. THE KEYS ARE TO STAY ON THE PERSON AT ALL TIME (SIC) WHILE ON SHIFT. THE MEDICATION CLOSET IS TO BE KEPT LOCK (SIC) UNLESS THE STAFF MEMBER IS ACTIVELY PASSING MEDICATIONS AND IS PRESENT IN THE ROOM. THE MEDICATION ROOM TO (SIC) BE CLOSED AND LOCKED WHEN NO STAFF ARE PRESENT IN THE MEDICATION ROOM." The facility's Key Form indicated the form was started on 3/21/15. The form indicated the facility staff did not sign on and/or off on the form on the following days, since the form was implemented on 3/21/15:</p> <p>-3/21/15 6 AM to 10 AM shift (off), 10 AM to 3 PM shift (on) and 10 AM to 3 PM shift (off).</p>			

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	-3/22/15 No shifts signed on and/or off for the entire day.			
	-3/23/15 11 PM to 6 AM (off), 6 AM to 10 AM (off) and 10 AM to 3 PM (off).			
	-3/24/15 No shifts signed on and/or off for the entire day.			
	-3/25/15 11 PM to 6 AM (off), 6 AM to 10 AM (off), 10 AM to 3 PM (on) and 10 AM to 3 PM (off).			
	-3/26/15 11 PM to 6 AM (off), 6 AM to 10 AM (on), 6 AM to 10 AM (off), 10 AM to 3 PM (on) and 10 AM to 3 PM (off).			
	-3/27/15 6 AM to 10 AM (off), 10 AM to 3 PM (on) and 10 AM to 3 PM (off).			
	-3/28/15 11 PM to 6 AM (off), 6 AM to 10 AM (off), 10 AM to 3 PM (on) and 10 AM to 3 PM (off).			
	-3/29/15 No shifts signed on and/or off for the entire day.			
	-3/30/15 11 PM to 6 AM (off), 6 AM to 10 AM (off), 10 AM to 3 PM (off) and 3 PM to 11 PM (on).			
	-3/31/15 10 AM to 3 PM (off).			

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	<p>Interview with the PD and administrative staff #1 on 3/31/15 at 4:15 PM indicated client H was no longer living at the group home. The PD indicated the client was discharged as the client went home to his mother's when he was discharged from the hospital. The PD and administrative staff indicated the facility was not able to determine how client H got his medications. The PD and administrative staff #1 indicated the facility staff all indicated they kept client H in sight except when the client was in his room in bed. The PD and administrative staff indicated the facility staff all indicated the medications were locked and staff had the keys on their person. Administrative staff #1 and the PD stated "Had to happen when taking nap and went into med room" while staff was doing the laundry. The PD indicated client H had one on one staffing at the time of the incident. The PD stated the one on one staffing meant "Line of sight." Administrative staff #1 stated the facility completed its investigation of the 3/17/15 incident "last Friday (3/27/15). The PD and administrative staff #1 indicated they were not able to interview client H as he was in the hospital. Administrative staff #1 indicated client H's mother made an additional allegation of abuse during the investigation regarding staff #5.</p>			

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	<p>Administrative staff #1 indicated the allegation should have been reported on the follow-up BDDS reports. The PD indicated client H's mother's allegation of abuse was not reported to BDDS and/or reported with the follow-up reports. The PD and administrative staff #1 indicated the facility's investigation did not indicate/include environmental factors of where client H's bedroom was in relation to the medication room. The PD indicated he did look at the environment during the investigation. The PD indicated client H would have to pass through the kitchen to get to the medication room. The PD indicated one staff was in the laundry room, one in the kitchen and one staff was gone on with 2 clients on an outing/in the community. Administrative staff #1 and the PD indicated the facility did not interview any clients and did not interview all staff who worked at the group home. Administrative staff #1 and the PD indicated they did not obtain and/or review client H's hospital records from the 3/17/15 hospitalization as part of their investigation. Administrative staff #1 indicated since client H went home with his mother, the facility could not obtain the hospital records.</p> <p>Continued interview with administrative staff #1 and the PD on 3/31/15 at 4:15</p>						

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	<p>PM indicated facility staff were allowed to return to work on 3/27/15. The PD indicated facility staff, who had not been suspended, were retrained to monitor clients and to lock the medication cabinet on 3/20/15. The PD indicated he would need to train staff who had been suspended on 3/31/15. The PD and administrative staff #1 stated the facility put in place a "key form" facility staff were to sign when they started their shift and when they finished their shift. The PD indicated the form would indicate who had/was responsible for carrying the medication key. The PD and administrative staff #1 indicated client H did not have a history of suicide attempts until the 3/17/15 incident with trying to cut himself with a knife. The PD indicated client H was not suicidal when he entered the group home as there was no documentation of suicide/suicidal ideation. The PD indicated he was not aware of the pre-admission paperwork in client H's record which indicated the client had a history of suicidal ideation and depression. Administrative staff #1 indicated she did not know where the former PD got the information in regard to self-injurious behavior from as indicated on the 1/15/15 reportable incident report when he threatened others with a knife.</p>			

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	<p>Interview with the PD on 4/1/15 at 12:15 PM and at 4:55 PM indicated client H had not been found by the garbage can on 3/17/15, the PD indicated this was the first he had heard of that. The PD indicated the interviews indicated client H was in the house when staff noticed he was having some problems and called the nurse, the PD and the doctor and then 911. The PD stated "[Client H's] being found by garbage cans was a mistake. Hospital misunderstood what staff said. The pills were found in the garbage, not the client by the garbage." The PD indicated client H had been on all his behavioral medications prior to coming to Dungarvin. The PD indicated he was not sure what symptoms client H demonstrated in regard to the client's Bipolar Disorder.</p> <p>Interview with staff #6 on 3/31/15 at 6:30 PM indicated he had worked on 3/17/15. Staff #6 indicated he had the keys on his person/carried them on his arm, and the medication cabinet was locked. Staff #6 stated when he went to administer client H's evening meds, the client's "meds were missing from the closet." Staff #6 indicated there were 25 pills missing from the client's bubble pack. Staff #6 stated "There was someone monitoring him. Never out of sight. He was to be in line of sight." Staff #6 stated "He was</p>			

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	<p>not happy here. Kept saying he wanted to go home." Staff #6 indicated client H had made 2 attempts at suicide. Staff #6 indicated one attempt was with a knife when client H indicated he would kill himself and threatened to cut his throat. Staff #6 indicated he did not know how client H was able to get his medications.</p> <p>Interview with staff #5 on 3/31/15 at 6:45 PM indicated he worked on 3/17/15 from 3 PM to 9 PM. Staff #5 indicated he did not see client H go into the medication room. Staff #5 indicated he did transport when he came in and then monitored client H when he returned. Staff #5 stated "He stayed with me. He cleaned dining room and then went to lay on his bed." Staff #5 stated "He checked on him 15 minutes and he was laying in bed but not asleep." Staff #5 indicated when client H got up he went outside and staff #5 followed him. Staff #5 indicated client H stayed outside for 45 minutes before returning to the house and sat in living room. Staff #5 indicated he went to assist client C with his shower and staff #6 monitored the client while he was gone. Staff #5 indicated he thought client H took a nap for 15 to 30 minutes. Staff #5 stated "Not unusual to take a nap." Staff #5 stated client H did not want to be at the group home, and client H would state "He would say he would kill</p>			

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	<p>himself."</p> <p>Interview with staff #1 on 3/31/15 at 7:00 PM stated client H was "Nice young man but he seemed to have some mental issues." Staff #1 indicated the client had pulled a knife on others when he first came to the group home. Staff #1 stated "He wanted everything his way." Staff #1 stated "He would hear voices that told him to do things. He would go after other clients. They would have to run to their rooms." When asked if client H had suicidal tendencies, staff #1 stated "Suicide was not one of them. He was more threatening to others than himself. He would threaten to kill himself if he could not go home." Staff #1 indicated client H had one on one staffing as the client had a staff assigned to him. Staff #1 stated the staff assigned to him may have more than one other client to assist, but if client H started to have behaviors, "He had one on one." Staff #1 indicated she worked on 3/17/15 but she was gone most of the time grocery shopping or taking a client to and from a class. Staff #1 indicated she worked the evening shift and for 4 hours in the morning. Staff #1 indicated the medication cabinet was locked and staff had the keys on their person. Staff #1 indicated staff #6 told her client H's medications were missing. Staff #1 indicated she took client H with</p>			

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	<p>her to pick up client E. Staff #1 indicated when they returned client H became upset when he overheard staff talking about the missing medications. Staff #1 indicated she talked with client H about the missing medications and client H indicated he took the medications and took 7 of the pills. Staff #1 indicated client H did not know which ones he took. Staff #1 indicated client H had told her he got the medications on the day shift. Staff #1 stated client H was "sluggish, slurring speech and lethargic." Staff #1 indicated the nurse was called and 911. Staff #1 indicated she was the staff who went to the hospital with the client. Staff #1 stated client H was "very sleepy at the hospital." Staff #1 indicated she did not how client #1 was able to obtain his medications.</p> <p>Interview with staff #8 on 4/1/15 at 7:10 AM and on 4/2/15 at 11:52 AM, by phone, indicated staff #8 did not work on 3/17/15. Staff #8 indicated facility staff would sometimes lay the medication key ring down to do some paperwork, but the staff were in the office area/med room. Staff #8 indicated the facility staff would pick up the keys and take them when they were leaving the office area. Staff #8 indicated the van keys were kept in the kitchen drawer. When asked what keys were on the van key, staff #8 indicated</p>				

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	<p>the van key was on the key ring and a key which went to a locked box that contained the workshop medications in it. Staff #8 indicated the locked box was in the medication cabinet. Staff #8 indicated client H had a 12 noon medication in the box. Staff #8 was not sure what the others keys went to.</p> <p>Interview with staff #4 on 4/2/15 at 12:01 PM, by phone, indicated staff #4 worked from 7:15 AM to 3:20 PM on 3/15/15. Staff #4 stated he worked in the medication room "most of the day on 3/17/15." Staff #4 stated he worked in the room "putting stuff on the computer." Staff #4 stated "I had them (med keys) going in and out of med cabinet." Staff #4 indicated he would give them to staff #3 when staff #3 passed the medications. Staff #4 indicated client H did not come into the medication room except to get his medication and to ask to cut out a picture the client had drawn. Staff #4 indicated he cut the paper out for client H as the client was not to have any sharps. Staff #4 stated he had "no idea" how client H got the medications.</p> <p>Interview with administrative staff #2 and the PD on 4/2/15 at 12:20 PM indicated medications should be locked at all times except when staff were administering the medications. The PD stated "I had a</p>			

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	<p>conversation with them (suspended staff) on 3/27/15 before they went to work." The PD indicated he did not have any written documentation the staff were formally retrained until 3/31/15 after the staff had returned to work. The PD indicated the facility staff were not filling the key form out as they should. The PD indicated he put another form which would be easier to understand in place on 4/1/15. When asked when did client H fall and hit his head, the PD stated "We heard from his mother. It was the same day of the incident. There is no evidence he fell and hit his head." The PD indicated the facility did not interview in regard to which clients were allowed to use the medication keys to get into the snack cabinet. The PD indicated client H's IDT met after the 3/7/15 incident with the knife and hospitalization. The PD indicated client H's mother had decided to take the client home after the IDT meeting so the IDT did not address the client's suicide attempts/behavior and/or threats. The PD indicated when the client did not go home, the team did not reconvene to address the client's identified behavioral needs. The PD indicated he would have to look for the date of the IDT meeting as it was not put on the hand written paper. The PD indicated they did not get to how the client was to be monitored as the client</p>			

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	<p>was no longer going to be in the group home at that time. The PD indicated the staff was to monitor the client one on one/keep in line of sight due to the client's 3/7/15 attempt of suicide and property destruction.</p> <p>Interview with client H's mother on 4/6/15 at 10:58 AM, by phone, indicated client H told her about the missing medications. Client H's mother stated client H indicated "The medications were laying on the desk in the office unlocked. All staff were in the back living room watching TV." Client H's mother stated client H indicated "He walked in there and got meds and walked out the front door and threw the meds away." Client H's mother indicated client H indicated he took the meds before he went outside and threw the medications away. Client H's mother indicated client H fell while he was outside and hit his head on the driveway. Client H's mother indicated client H told her all 8 clients were home at the time this occurred. Client H's mother indicated client H had not attempted suicide before, but did have Depression.</p> <p>Interview with staff #2 on 4/7/15 at 8:55 AM, by phone, indicated she worked the night shift on 3/17/15. Staff #2 stated she came at 10 PM and client H was sitting</p>				

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	<p>on the couch holding the remote control "looking drowsy." Staff #2 indicated she asked client H why he was up and client H did not respond. Staff #2 stated "He just looked drowsy." Staff #2 indicated facility staff then told her what happened. Staff #2 indicated they were waiting for the ambulance to get to the group home. Staff #2 indicated client H was not outside the group home when she came into work. Staff #2 indicated she also worked during the morning shift on 3/17/15. Staff #2 indicated she did not pass medications on 3/17/15. Staff #2 stated "We would have to monitor [client H] all the time. Can't leave [client H] by himself." Staff #2 indicated she did not see client H go into the office on the morning shift. When asked if she saw medications sitting out, staff #2 stated "No, never." Staff #2 indicated clients A and E were the only 2 clients who could use the med room key to access the snacks/food in a cabinet in the medication room. Staff #2 indicated facility staff would need to be present when the clients used the key.</p> <p>2. The facility's reportable incident reports and/or investigations were reviewed on 3/31/15 at 2:10 PM. The facility's 2/6/15 reportable incident report indicated "[Client A] called the agency's</p>			

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	<p>supervisor on call on Friday February 6, 2015 to report that while using the bathroom at Day Program at (sic) one of his peers came from behind, lowered his pants and underwear, and sexually assaulted him. [Client A] informed the on call supervisor that he did not report this incident to his supervisor at day program because the individual who assaulted him was standing next to the supervisor. [Client A] claimed that when he got home after the incident, he excreted blood from his anus and experienced some pain. [Client A] was immediately sent to the ER (emergency room) where he was checked and they found some tearing in the anal cavity. Police officers interviewed [client A] who gave them the name of the peer he accused of sexually assaulting him. The attending physician prescribed 2 medications for [client A] to combat the possibility of him contracting a sexually transmitted disease (STD). The prescribed medications are: Lopinavir Ritonovir 500mg (milligrams), 2 tablets 2 times daily and Truvada 200 mg. 1 tablet once daily, and he is to take these medications for 26 days. [Client A] will have to see an infection control doctor within a week, [client A] will also need to get some labs done by 2/10/15 to check on the new medication he is taking. The team continues supporting [client A]</p>			

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	<p>encouraging him to report issues as soon as they happen. The team will also follow the physician's instructions to ensure that [client A] does everything, including med (medication) administration and appointments accordingly."</p> <p>The facility's 2/13/15 follow-up report to the 2/6/15 incident indicated the following:</p> <p>"1) What safety measures are in place at the individual's workshop to ensure the individual's safety? [Client A] is currently not going to his day program while the organizations are working on policies to ensure his and other individuals' safety at day program.</p> <p>2) What emotional support was given to the individual? The team continues supporting [client A] with the issue and encouraging him to report issues like these as soon as possible. [Client A] is being informed that he did not deserve the treatment he got from his peer.</p> <p>3) What actions are the police taking? The police are investigating the matter.</p> <p>4) Please provide an update following the lab work on 2/10/15. The labs came back negative for any STDs.</p>			

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	<p>5) When will the individual see the infection control doctor? Please provide a date. [Client A] saw [name of doctor] on 2/12/2015 and is doing fine right now and will have to see him again in 6 weeks. The team will continue supporting [client A] by following the doctors' instructions and by finding him a therapist to help him process the incident better."</p> <p>The attached 2/13/15 Day Program Investigative Report indicated the day program became aware of the incident on 2/9/15 as the incident had occurred on 2/6/15 at their facility. The day program's investigation indicated "XX (perpetrator) reported that [client A] approached him and initiated the physical contact that the two of them had in the bathroom stall. XX reported [client A] was a willing participant. 1. [Client A] reported that XX approached him without his consent and that he was not a willing participant in the physical activity in the bathroom stall. XX appeared to be forthcoming in when describing the incident and providing details. [Client A's] account of the incident matched XX's in the physical contact description but that it was unwanted. [Client A's] answers became more vague when specific questions were posed to him regarding his responses to</p>			
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	<p>the incident, when his residential staff were notified, and why almost 5 hours passed before a staff person was notified. It is clear that something happened in the bathroom staff during the afternoon transport time and involved sexual contact. It is unclear as to whether both parties gave consent as it is [client A's] word against XX and XX's word against [client A]. There were no other known witnesses to this incident. As a result, it could not be determined if XX sexually assaulted [client A]. It could not be determined if [client A] consented to the physical interaction of a sexual nature with XX. Therefore, the allegation of sexual assault was unsubstantiated. 2. As both XX and [client A] have legal guardians, and per Adult Protective Services (APS); anyone with a legal guardian cannot give consent for any sexual act, regardless of functioning level, with consent without consent from the legal guardian; it appears that both individuals' rights were violated as neither could legally give consent for the sexual contact."</p> <p>The day program's undated witness statement by the day program's workshop supervisor #1 indicated "...There is no supervision in the bathrooms. [The name of the perpetrator] has made allegations about other individuals doing the same</p>			

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W 153 Bldg. 00	<p>thing to him in the past...." The undated witness statement indicated "...7. What is your understanding of the history of the relationship between [client A] and [name of perpetrator]? These two are always on and off. Over the past couple of weeks, [the name of perpetrator] w 483.420(d)(2)</p> <p>STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on interview and record review for 2 of 8 allegations of abuse, neglect and/or injuries of unknown origin reviewed, the facility failed to report an allegation of abuse made during an abuse/neglect investigation regarding client H, and to report an allegation of possible neglect in regard to bed bugs at the group home which involved clients A, B and D.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, facility Generated Event Reports (GER-internal incident reports) and/or investigations were reviewed on 3/31/15 at 2:10 PM and on 4/2/15 at 12:05 PM. The facility's 3/17/15 reportable incident report indicated "On 3/17/2015 while staff were getting ready to administer</p>	W 153	<p>The Program Director/QIDP failed to include the additional allegation of abuse made by Client H's mother in the follow up report to the 3/17/15 incident involving Client H and/or failed to complete a separate IR for the additional allegation. However, this allegation was investigated and is included in the investigation into the 3/17/15 incident involving Client H.</p> <p>The Program Director/QIDP reported that bed bugs had been found in the home on 8/11/14. Since that time Dungarvin has been treating the bed bugs in the home with professional extermination services and staff have been monitoring the bed bugs via a daily bed bug cleaning checklist. Plastic mattress covers were placed all mattresses and box springs in the home as a</p>	05/10/2015

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	<p>[client H's] medications, they discovered that his medications were missing from the med (medication) cabinet. Staff looked everywhere for the medications and could not find the meds. [Client H] has been known for throwing things in the trash can and they checked the trash can and found the meds in the trash can inside a [name of store] plastic bag. There were some meds missing and when asked about it, [client H] told staff that he had taken his meds from the med cabinet earlier in the day. He also told staff that he took about 7 of the pills. Staff asked him what he had done with the other medications and he said that he had thrown them away. A few minutes later [client H] started showing signs that he was not doing well. His breathing changed and he started sweating. The emergency number was called and police and ambulances attended the scene. [Client H] was taken to the ER (emergency room) at [name of hospital] where he was admitted. [Client H] is still admitted and is listed as 'stable'...."</p> <p>The facility's 3/27/15 Investigation Report indicated "I. History/Background: This report addresses allegations of abuse leveled against 6 staff members at the Oxford Group Home. On 3/17/15, evening staff members discovered individual [client H's] medications were</p>		<p>protective measure and persons served have been free from bed bug bites since the initial infestation on 8/11/14. The bed bugs have been managed since that time and several rounds of professional treatments have occurred, however the bed bugs have never been successfully eradicated from the home. No new infestation of the home occurred which required an additional IR nor was there an allegation or suspicion that neglect had occurred related to the bed bugs being present and/or the management or treatment.</p> <p>In response to the incident involving Client H, the Program Director/QIDP will be retrained by 5/10/15 on the expectation that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown origin will be reported immediately to the administrator/Area Director and/or to state officials according to state law and established procedures. All agency staff, including Program Director/QIDPs and Area Directors, are retrained on this expectation during annual conditions of employment mandatory trainings. System wide, all Program Director/QDDPs will review this standard and assure that this concern is being addressed at all Dungarvin ICF-IDs.</p>		

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	missing. Staff searched the whole house looking for the medications and still could not find them. Staff decided to look for the medications in the trash cans as [client H] has thrown things in there before. Staff found the meds that were still in bubble packs in the trash can, but there were about 25 pills missing from all the bubble packs that had been thrown out. [Client H] was asked about this and admitted that he took the medications sometime during the day and threw them in the trash. Asked about what happened to the medications that were no longer in the bubble packs, he told staff that he ingested 7 of them and threw away the rest. [Client H] started having slurred speech, looked tired and his skin was flushed and emergency medical assistance was sought for him, leading him to get admitted at [name of hospital] in [name of city]. Staff are trained to ensure that the med cabinet, where [client H's] meds are stored, is always locked and the meds secured in there. Staff are also trained to keep the med room door locked whenever there is no staff person in there. [Client H's] mother also alleged that staff [staff #5] purposefully gave [client H] an overdose of medications and that he (client H) had fainted on the day he took his meds and was left lying outside for 2 hours." Review of the facility's reportable incident reports from			

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	<p>1/15 to 3/15, the facility's 3/17/15 reportable incident reports and the follow-up reports indicated the facility failed to report the additional allegation of abuse made by client H's mother.</p> <p>Interview with the PD (Program Director) and administrative staff #1 on 3/31/15 at 4:15 PM indicated client H's mother made an additional allegation of abuse during the investigation regarding staff #5. Administrative staff #1 indicated the allegation should have been reported on the follow-up BDDS (Bureau of Developmental Disabilities Services) reports. The PD indicated client H's mother's allegation of abuse was not reported to BDDS and/or reported with the follow-up reports.</p> <p>2. Interview with administrative staff #1 and the Program Director (PD) on 3/31/15 at 1:25 PM indicated clients A, B, C, D, E, F and G would be going to a hotel to stay for one night. The PD indicated the clients would leave the group home at 8:00 AM on 4/1/15. When asked why, administrative staff stated "For the treatment of bugs." When asked if the group home had bed bugs, administrative staff #1 stated the group home was being treated for "all kinds of bugs, not just bed bugs." Administrative staff #1 indicated the group was</p>			

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	<p>undergoing its second round of sprays/treatments for bed bugs. Administrative staff #1 and the PD indicated one bed bug was found on the bed of a different client last week. Administrative staff #1 stated "Now in second bedroom with bug casings (nesting). We decided to move everyone out to remove some paneling." Administrative staff #1 and the PD indicated the bed bugs were originally in client C's bedroom (front area of the group home) a few months ago but were not in the back bedrooms of the group home.</p> <p>During the 3/31/15 observation period between 5:55 PM and 7:20 PM, at the group home, there were 6 holes on the back living room walls, with plaster showing and/or missing plaster. One area on the wall had a 2 by 4 piece of plywood covering the area. The hallway closet had tubs of clothes in the 3 large plastic containers. One of the plastic containers did not have a lid on the container. Client A carried a load of clothes and his bed linens to the laundry room to wash. Facility staff did not assist/encourage the client to wash his clothes in hot water. The living room couches were covered with a sheet like material. During the observation period, facility staff did not sit down on any</p>			

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	<p>furniture in the group home, unless they were in the office area. Interview with client A on 3/31/15 at 6:00 PM indicated the facility removed the panels from the wall and were replacing the panels with drywall.</p> <p>During the 4/1/15 observation period between 5:41 AM and 7:20 AM, at the group home, client A was packing a bag to take with him to the hotel. Staff #1 and staff #7 wore gloves during the observation period when in the kitchen, cleaning and/or removing mattress covers from the back bedrooms of clients A, B and D. Staff #7 took the mattress covers outside. Clients A, B and D's clothes were bagged up in dark trash bags and placed on the back living room couch of the group home. Client B and D's bedroom had a missing wall, where paneling used to be with a plywood board covering the hole in the wall. The plywood covered the length of the wall. Clients B and D's beds had wooden frames with wooden type floors made of vinyl. Carpet was in the living room, hallway and back living room.</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 3/31/15 at 2:10 PM. The facility's reportable incident reports and/or investigations form 1/15 to 3/15 indicated</p>				

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	<p>the facility did not report a bed bug being found 1 week ago in a client's bedroom, and the tearing out of paneling to attempt to eradicate the bed bugs which were going to cause the clients to move to a hotel for one night.</p> <p>Interview with administrative staff #1 and the PD on 3/31/15 at 4:15 PM indicated the facility had a bed bug policy. When asked if the facility had reported the bed bugs at the group home, administrative staff #1 indicated the bed bugs were initially reported when client C had bed bugs in his room. The PD indicated he thought it was reported 7 months ago. Administrative staff #1 indicated she thought the bed bugs report had been more recent than 7 months. Administrative staff indicated the bed bugs had not been reported that were found last week which resulted in the paneling being removed and replaced with drywall.</p> <p>Interview with client E on 4/1/15 at 6:12 AM indicated his bedroom was located at the back of the house. Client E indicated he did not have bed bugs. Client E stated "I keep the ones who have bed bugs out of my room."</p> <p>Interview with client A on 4/1/15 at 10:15 AM indicated staff had seen a bed</p>			

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	<p>bug in his bedroom. Client A stated "Staff saw them. I don't know what they look like." Client A indicated he had the same mattress he had when he moved into the group home 3 years ago. Client A indicated his mattress had not been replaced. Client A stated "They just keep changing bed sheets not covering of mattress."</p> <p>Confidential interview N indicated clients A, B and D's bedrooms had bed bugs. Confidential interview N indicated the facility was going to spray the entire house on 4/1/15 and replace the paneling in the group home. Confidential interview N stated "More than 1 bed bug found in their rooms." Confidential interview N indicated the clients' clothes were kept in the closet.</p> <p>Confidential interview P stated the bed bugs had been in client C's bedroom but it had "been months." Confidential interview P stated "It was infested behind panels" with bed bugs. Confidential interview P indicated clients A, B and D had bed bugs in their bedrooms. Confidential interview P indicated all clients had mattress covers on their bed. Confidential interview P stated they would try to change the mattress covers of clients A, B and D's beds "every three days." Confidential interview P indicated</p>			

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	<p>bed bugs would be inside of the clients' mattress covers on the clients' mattresses. Confidential interview P indicated the bed bugs started in client C's bedroom. Confidential interview P indicated clients' clothes were kept in the hall closet. Confidential interview P indicated confidential interview P thought clients A, B and D's mattresses had been changed.</p> <p>Interview with administrative staff #2 on 4/2/15 at 12:20 PM indicated the facility had a bed bug policy. Administrative staff #2 indicated the facility's policy did not indicate how the facility was to eliminate the bed bugs. Administrative staff #2 indicated the mattresses would be replaced.</p> <p>Interview with the maintenance director on 4/1/15 at 2:15 PM indicated the Oxford group home had problems with bed bugs. The maintenance director stated "We have been dealing with bed bugs for over a year." The maintenance director stated some clients had gotten a new mattress due to "being worn out" not due to the bed bugs. The maintenance director indicated clients A, B and D's mattresses had not been replaced and they need to be replaced. The maintenance man indicated he was aware the facility staff was changing the</p>				

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W 154 Bldg. 00	<p>mattress covering on the bed. When asked what was being done to get rid of the bed bugs, the maintenance director stated "We are defogging two times a day and using ground spray today (4/1/15) and tomorrow (4/2/15)." The director indicated he had purchased a formula (Total Pest Control spray) hotels used. The maintenance director stated all the paneling in the home was being torn out as he could see "nesting" behind the panels. The maintenance director indicated he checked the home 2 days ago and he did not find any live bed bugs. The maintenance director indicated the facility would need to replace the carpet to prevent the bed bugs from returning. The maintenance director indicated the carpet was not going to be replaced at this time.</p> <p>This federal tag relates to complaints #IN00169980 and #IN00169949.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on observation, interview and record review for 1 of 8 allegations of abuse and/or neglect reviewed, the</p>	W 154	It is Dungarvin's intention to comply with the expectation that all allegations will be investigated	05/10/2015			

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	<p>facility failed to conduct a thorough investigation in regard to the client's overdose and in regard to an additional allegation of abuse made by client H's mother.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, facility Generated Event Reports (GER-internal incident reports) and/or investigations were reviewed on 3/31/15 at 2:10 PM and on 4/2/15 at 12:05 PM. The facility's 3/17/15 reportable incident report indicated "On 3/17/2015 while staff were getting ready to administer [client H's] medications, they discovered that his medications were missing from the med (medication) cabinet. Staff looked everywhere for the medications and could not find the meds. [Client H] has been known for throwing things in the trash can and they checked the trash can and found the meds in the trash can inside a [name of store] plastic bag. There were some meds missing and when asked about it, [client H] told staff that he had taken his meds from the med cabinet earlier in the day. He also told staff that he took about 7 of the pills. Staff asked him what he had done with the other medications and he said that he had thrown them away. A few minutes later [client H] started showing signs that he</p>		<p>thoroughly and in a timely fashion. We expect the Program Director/QIDP to keep a record of this investigation along with the incident and incident follow up as submitted to BQIS. This investigation is to include all related evidence, witness statements, a review of previous similar incidents and all pertinent information necessary to prove or disprove the allegation.</p> <p>In this case, the Program Director responsible for this ICF facility at the time of this incident completed a thorough investigation into the incident but based on the information that could be ascertained it could not be determined how Client H accessed his medications. All staff who worked in the home from the last time the medications were verified to have been present through to the time the overdose was discovered were suspended and interviewed. Attempts were also made to interview Client H and his mother, however both refused to be interviewed and refused to grant Dungarvin access to the hospital records for Client H related to the incident. The information which was provided to the surveyor by Client H's mother regarding the medications being out on a desk and staff failing to supervise Client H due to being in the "back living room watching television" was never provided to Dungarvin</p>	

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	<p>was not doing well. His breathing changed and he started sweating. The emergency number was called and police and ambulances attended the scene. [Client H] was taken to the ER (emergency room) at [name of hospital] where he was admitted. [Client H] is still admitted and is listed as 'stable.' The agency suspended all the staff members who worked on this day at this site. Staff members are required to keep the medications locked in the med cabinet and never leave the med cabinet keys where individuals can take and use them...The agency policies require staff members to lock medications and ensure that no one has access to the meds except with staff. Staff members will be retrained and appropriate disciplinary action will be taken for those who did not follow company policy."</p> <p>The facility's 3/17/15 GER indicated staff #1 wrote the 3/17/15 GER. The 3/17/15 GER indicated the incident occurred at 8:15 PM on 3/17/15. The GER indicated client H was sent out to the hospital around 9:00 PM. The GER indicated "[Client H] arrived home from accompanying staff for a transport of a house mate (sic) from an appointment to his home site. Staff noticed that [client H's] skin was flushed and he was sweating profusely. It was discovered</p>		<p>by Client H or his mother despite attempts to interview Client H and several conversations with his mother during the investigatory process. The information provided to the surveyor that staff were in the "back living room watching TV" is also not likely as there is no working television in the back living room at the home. Based on the scheduled and documented activities occurring during the timeframe of the incident on 3/17/15 it is also not likely that all 8 clients were in the home at the time that Client H accessed his medications as was further alleged to the surveyor. The allegations related to staff purposely overdosing Client H and the allegation that Client H had fallen and hit his head in the driveway were thoroughly investigated and were unsubstantiated as is documented in the investigation report into the incident.</p> <p>The Program Director/QIDP will be retrained by 5/10/15 on Dungarvin's expectations regarding how to thoroughly conduct investigations in an effort to continue to complete thorough investigations into all allegations of abuse/neglect/exploitation, injuries of unknown origin, and peer-to-peer aggression. All Program Director/QIDPs will report findings of the investigations to the administrator/Area Director within</p>	

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	<p>that some of [client H's] medications were missing. [Client H] was asked if he took them and he remarked that he took seven pills. Shortly after this discovery [client H] started having slurred speech. The nurse and the program director on call were contacted and staff were directed to call [client H's] primary care physician. The after hours answering service was called and the doctor on call was paged. While waiting for the doctor to call, [client H's] symptoms worsened. He began to stagger and his slurred speech became worse. The nurse on call was contacted again and she directed staff to call 911. 911 was called and dispatched to the home site." The 3/17/15 GER indicated "...[Client H] took an overdose of his medications and experienced lethargy, slurred speech, pale skin and subsequent hospitalization...."</p> <p>The GER indicated client H was admitted to the hospital for observation. The GER indicated "This is a 1:1 (line of sight) individual who should never be out of staff sight. That said, there is no acceptable explanation to how he had access to his medications. The med cabinet should always be locked and staff, and only staff members should have access to the medications. So between the 1:1 staff and the med passer always having the keys in (sic) their person, there is no reason why this individual</p>		<p>5 business days and inform the Area Director of the progress of the investigation throughout the investigation process while it is being completed. The Area Director will provide ongoing feedback to the Program Director/QIDP to ensure a thorough investigation is being conducted. The Program Director/QIDPs will also maintain an annual file of all incident reports filed on behalf of each client in the home. The Program Director/QIDPs will submit an investigation summary to the Area Director and maintain copies of all related investigation documentation and attach as supplemental documentation to the original incident reports in the file. The Area Director will review investigations with the State Director and/or the Director of Human Resources in an effort to determine that a thorough investigation has been completed and the corrective action(s) are prudent. System wide, all Program Director/QDDPs will review this standard and assure that this concern is being addressed at all Dungarvin ICF-IDs.</p>	

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	<p>should be doing this...."</p> <p>The facility's 3/24/15 follow-up report to the 3/17/15 incident "The investigation is still ongoing, but the individual served has been discharged from the hospital and from the agency by his mother. Staff will continue to ensure the safety of individuals by keeping their medications securely locked in the med cabinet."</p> <p>A second 3/24/15 follow-up report indicated the Bureau of Developmental Disabilities Services (BDDS-state reporting and licensure agency) indicated the state agency had the asked the following questions (not all inclusive):</p> <p>"1. Does the individual have a history of suicide ideation? On 3/72015, this individual had to be tasered by law enforcement personnel after threatening to cut himself with a knife. [Client H] had a knife in his hand and refused to listen to police when they asked him to drop it. He was tasered and later admitted to [name of behavioral center] for psychiatric evaluation.</p> <p>2. Did the individual intentionally take the wrong dose of medication? Based on the investigation that is still open, the individual intentionally took these medications...6. What treatment was</p>			

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	<p>completed at the hospital? No information was provided about this since the individual's mother took him home with her. The individual has been discharged from Dungarvin services by his mother. The agency will continue requiring staff members to keep the medication locked and safe in the medication cabinet...."</p> <p>The facility's 3/27/15 Investigation Report indicated the facility's investigation was conducted from 3/17/15 to 3/24/15 by the Program Director. The facility's investigation indicated "I. History/Background: This report addresses allegations of abuse leveled against 6 staff members at the Oxford Group Home. On 3/1/15, evening staff members discovered individual [client H's] medications were missing. Staff searched the whole house looking for the medications and still could not find them. Staff decided to look for the medications in the trash cans as [client H] has thrown things in there before. Staff found the meds that were still bubble packs in the trash can, but there were about 25 pills missing from all the bubble packs that had been thrown out. [Client H] was asked about this and admitted that he took the medications sometime during the day and threw them in the trash. Asked about what happened</p>				

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	<p>to the medications that were no longer in the bubble packs, he told staff that he ingested 7 of them and threw away the rest. [Client H] started having slurred speech, looked tired and his skin was flushed and emergency medical assistance was sought for him, leading him to get admitted at [name of hospital] in [name of city]. Staff are trained to ensure that the med cabinet, where [client H's] meds are stored, is always locked and the meds secured in there. Staff are also trained to keep the med room door locked whenever there is no staff person in there. [Client H's] mother also alleged that staff [staff #5] purposefully gave [client H] an overdose of medications and that he (client H) had fainted on the day he took his meds and was left lying outside for 2 hours."</p> <p>The facility's 3/27/15 investigation indicated the facility was still interviewing staff on 3/25/15. The facility's investigation indicated staff #2, #3 and #4 worked during the day on 3/17/15. The facility's investigation indicated staff #4 was in the medication room during most of the day shift doing paperwork and checking the medications. The facility's investigation indicated staff #2, #3 and #4 indicated client H was not out of staff #2 and #3's sight during the day shift. Staff #2, #3 and #4 indicated</p>						

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	<p>the medications were kept locked. Staff #4's 3/17/15 and 3/18/15 witness statements indicated staff #4 came in at 7:20 AM on 3/17/15 indicated, the staff cleaned up the group home and made beds until 9:00 AM when staff #4 went to assist client D to toilet and get him ready to leave for the day program. The staff's witness statement indicated staff #4 then went to the medication room to complete paperwork, review medications and labs until around 2:50 PM when staff #4 went grocery shopping. Staff #4's witness statement indicated staff #4 left the med room "about 5 or 6 times" during his shift. The staff's witness statement indicated client H only came in the medication room to ask for scissors to cut something out (staff #4 cut it out for him) and to get his medications. Staff #4's witness statement indicated staff #4 had the medication keys "for most of the day." Staff #4 indicated staff #3 also had the med keys as she was the medication passer for the day shift. Staff #4's witness statement also indicated client E had the medication keys during the day shift. Staff #4's witness statement indicated "...12. You said [client E]? [Client E just wanted something from the food cabinet and he gave the keys back to me (staff #4)...20. Does [client E] regularly get the keys to access the cabinet? Sometimes if he is preparing</p>			

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	<p>lunches for the next day he will be given the keys but staff will be standing there with him. He does not go in there by himself. Also he was not accessing the med cabinet, but there is a cabinet next to the med cabinet with snacks. Yesterday he was getting a snack for his lunch...." Staff #4's 3/25/15 witness statement indicated staff #7 also worked at the group home between 7 AM and 9 AM. The witness statement indicated "...when [staff #7] was at the house she followed him everywhere...." The facility's investigation indicated the facility failed to interview staff #7 as staff #7 had worked during the morning shift on 3/17/15.</p> <p>The facility's 3/17 to 3/24/15 investigation indicated staff #3 passed medications to client H at 10 AM, 12 PM and 2 PM. Staff #3's witness statement indicated "...(I do not remember if I am the one who passed [client H's] 3pm meds because sometimes he gets mad when we change shifts)...Yes I had the keys in my pocket and when I passed meds I opened (medication cabinet). 8. Was the med cabinet locked each time you saw it? Yes, it was locked. We never leave it open. We take the meds, close it, and lock it. We do not leave the med room with the med cabinet unlocked...."</p>			

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	<p>The facility's 3/17 to 3/24/15 investigation indicated staff #1, #5 and #6 worked during the evening shift. The facility's investigation indicated staff #1 also worked from 6 AM to 10 AM on 3/17/15. The facility's investigation indicated the following staffs' witness statements (not all inclusive):</p> <p>-On 3/18/15 staff #1 indicated staff #1 worked from 6 AM to 10 AM and 2:07 PM to 10 PM on 3/17/15. Staff #1's witness statement indicated she was in the front of the house when she first came in while staff #3 did her documentation. Staff #1's statement indicated "...At 3:00 PM, other evening staff members came in. [Staff #6] came first and [staff #5] just after him. Staff [#2] returned with the [name of day program] guys that she had gone to pick up. The two morning staff went back and did their narratives, and I remained with staff [staff #5] in the front...Dinner was started early because we had to go grocery shopping and transport [client E's] class...." The witness statement indicated client H became upset when staff and clients were getting ready to leave "...about 5:40 PM. [Client H] had started to show some aggression as we were leaving. He was grabbing rocks outside and was pacing outside. So I left with the two</p>			

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	<p>individuals for shopping and for the other individual's class. We arrived home at just about 8:00 PM from shopping to unload groceries and pick [client E] up. [Staff #6] called me to the office, and said 'you passed meds this morning during your 6a-10p, where are [client H's] meds because there are non (sic) in his container?' I told him that I did not know where they went as they were there in the morning when I left. My first thought was since [staff #4] was home all day, he could have placed them somewhere differently. So we called him, and he said he did not know where the meds were and that he he did not touch them. He asked me to look around and call him back. He also told me to call [staff #3] who had passed meds at 12. I did not call [staff #3] because I believe [staff #6] was going to call him (sic); it was time for me to go pick [client E] from the [name of police department]. When we left I was told that [client H] had been very cooperative, cleaning and taking out the trash assisting staff around the house. So when we had to go and pick [client E] up from [name of police department] we asked [client H] to go with us...[Client H] was in a good mood and talking to staff. He came into the house, [staff #6] asked me to come to the office. [Staff #6] said the meds were found in the trash can outside. [Client H] came behind me and</p>			

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	<p>said 'I did not steal my meds, don't accuse me of that.' I did not say anything, [staff #6] responded and said 'we are not accusing you of anything.' [Client H] went back and sat on the couch. [Staff #6] asked me to talk to him and find out if he had taken his meds or if he had ingested them. 2. Did you know at the time why he asked you to do this? Because he was assuming that he had ingested some of his meds. 3. What happened after that? I took him (client H) to the dining area where I could speak to him privately. I asked him to tell me the truth and he promised to tell me the truth. I asked him if he took his meds, and he said 'yes' and I asked him where he put the meds and he said in the trash can outside. I asked him if he ingested any of the meds and he said he had. I asked him how many he took, and he said 7. I asked him if he knew which ones he took, and he said he did not know. I asked him how and when he got the medications, and he said he got the medications when staff [staff #3] was there. I did not know what time that meant. He would not elaborate. When I asked him what he meant, he said he did not want to talk about it. 4. What did he look like at this point? His face was flushed, his eyes were red and he was sweating. I went and told the other staff what he told me, but according to the</p>			

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	<p>staff count, 25 meds were unaccounted for. [Staff #6] called the nurse, the nurse directed him to call his primary care doctor. [Staff #6] called after hours doctor on call and he got the answering service and they told him the doctor on call would call him as soon as possible. We were monitoring [client H] at this time and he was starting to get wobbly at this time and his speech was slurred, we called the nurse again and we were told to call 911. We called and they arrived in about 5 minutes, and the primary care doctor called at the same time and we told him 911 was already on site and he told us that that (sic) was exactly he was going to direct us to do (sic)...." Staff #1's witness statement indicated she followed the ambulance to the hospital. Staff #1's witness statement indicated no pills were found in the trash can with the bubble packs. Staff #1 indicated when she was in the home, the medication cabinet was locked and staff had the keys. Staff #1's witness statement indicated she did not have the keys during her shift. Staff #1's 3/19/15 witness statement indicated "...Staff members always follow [client H] especially when he tries to move to the back of the house because he goes out to pick stones up, or pulls the fire alarms. He may have stolen the meds sooner, but ingested them later after hiding them in</p>			

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	<p>his room for a while...it is hard to believe that he would have been able to do that because staff [staff #3] is very careful with the meds...."</p> <p>-On 3/18/15 staff #5 stated he was "assigned" to work with client H on the evening shift. Staff #5 indicated he did the transport to pick up other clients but client H stayed at home with staff #6 as client H was outside standing by the trash can with staff #6 monitoring the client from the front door. Staff #5 indicated when he returned, staff #1 was leaving to go shopping with 2 other clients. Staff #5's witness statement indicated client H wanted to go with them, but had not told staff #1 he wanted to go. Staff #5 indicated he told client H he would take him out once staff #1 returned to the group home as staff #1 could not watch the three of them. Staff #5 indicated client H then went back into the house and started cleaning up the kitchen and took a nap. The staff's witness statement indicated "...3. Does he take naps during our shifts? Once in a while, but yesterday was the first time he had asked to take a nap in about two weeks. I went inside his room to check him, and I realized that he had his suitcase packed and for his trip home...He slept for about 30 minutes, because I checked him, and I realized that he followed me. He then</p>			

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	<p>went outside and was walking by the stones, trying to collect, but I was with him and asked him to come back inside since it was a little cold. He was outside with me for about 45 minutes. He went back inside at about 8pm, and he went out there to assist carry the groceries (sic). I then asked [staff #1] if they were going to pick [client E] up, and she agreed to take him. It was at this time that staff [staff #6] said that [client H] needed to take his meds before going out since it was his med time. That was when the meds were discovered missing...After we discovered the meds missing, [client H] looked uncomfortable and his anxiety levels went up. Staff took him and [client A] out for transport. After they left, I went to check his packed bag to see if he packed the meds, and they were not there. Then we checked Therap (computer system) to see if they had been given before, and we saw that staff [staff #3] had passed them. We then took a torch and went outside. We checked the trash cans; we checked the trash cans because I remembered that when [client E's] wallet went missing [client H] had thrown it in the trans (sic) can. I opened the trash cans, at the top there were those big black trash bags. When I lifted the first one, under it, on top of another one, there was a [name of store] paper bag with the medications</p>			

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	<p>inside...After I clocked out, [client H] told me that he took the meds and that he trashed the other ones. I asked him when he did this, and he said it was during the day. I asked him if he remembered the meds that he had taken and he said he did not know...." Staff #5 indicated the med cabinet was kept locked and that staff #6 had the keys on his wrist. Staff #5 indicated he did not see client H fall and/or have a seizure. Staff #5's 2/25/15 second interview indicated "...2. What did you do with [client H] all day? Please note that I (staff #8) had other clients to deal with since we had all 8 guys at the house...5. Did staff follow every time or was he alone? The only time I did not follow him was when he was in his room napping, when he went to [name of police station] to pick [client E] up, and when I was on transport. The rest I always had my eyes on him...12. Why does he have 1-on-1 staff? I will say that [client H] had most of staff time not 100% 1:1. We get assigned more than one individual at the site and he was my individual for that day and I was following him everywhere. There were times when I would do other duties I was scheduled to do on that day, for example, I helped [client C] with his shower and when I did this, [staff #6] watched him. Each time I stepped aside, I would have [staff #6] watching him...."</p>			

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	-On 3/18/15, staff #6 indicated client H was watching TV in the living room when staff #6 came in to work. Staff #6 indicated client H "... went out of the house to where the trash cans are and started collecting stones." Staff #6's witness statement indicated staff #6 followed the client outside where the client picked up stones and paced back and forth between staff's car and the trash cans until staff #1 came to the door to check on him and he followed staff #1 in the house. Staff #6's witness statement indicated client H picked up the house phone and looked at a list of posted phone numbers in the living room area, and then started writing on a piece of paper and pen he had gotten out of a kitchen drawer. The witness statement indicated client H ran towards a staff person to protect her when another client (client D) ran towards the staff. Staff #6 indicated staff #6 told client H "...not to touch the housemate or yell at him. I told him that staff would redirect the housemate. He did not like that and walked out of the house through the front door and went to his previous spot between my car and the trash cans and later started picking stones again...." The witness statement indicated staff #5 followed the client outside until client H returned to the house and started				

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	<p>cleaning. Staff #6's witness statement indicated client H then sat on the living room for 10 minutes before going to his bedroom to take a nap. Staff #6 indicated it was at the 8 PM medication pass where the client's meds were discovered missing. Staff #6 indicated they looked in other clients' med containers and "...We checked the whole med closet and we did not find the meds anywhere. So by that time I had them leave to go and pick [client E] and when they left I searched the whole med office (sic). I still didn't find them. Then [staff #5] told me that when he was in [client H's] room, he had noticed that his bag was packed and ready for him to visit his mother so he went and looked for the meds in there and they were not in there. Then he decided to check the trash cans inside the house and they were not there, but when he checked those outside the house, he found the meds in one of the trash cans in a [name of store] shopping bag. We checked the bag and all of his bubble packs were there. We were wondering if we needed to pass the meds since we found them in the trash. That was when we discovered that some pills were missing...when we further investigated we realized that there were 25 popped and not signed for..." Staff #6's witness statement indicated he did not see client H fall on the concrete, and</p>			

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	<p>client H did not complain about falling.</p> <p>The facility's 3/17/15 to 3/24/15 investigation indicated "...On 3/20/15, the social worker at [name of hospital] reported that [client H] told him that he broke into the medicine cabinet to take his medications. On the same day when asked by this PD, [client H] said more than once he did not know how he got his medications..."</p> <p>The facility's 3/17 to 3/24/15 investigation indicated the following:</p> <p>"a. The med cabinet was left unlocked sometime after 12pm on 3/17/15. While none of the staff persons at Oxford remember when [client H] was out of sight, it is clear that the individual was alone for some time and that was the time that he took the medications from the med room to another location. It is possible that when he took the medications from the med room, he hid them somewhere for a while and ingested them later. It is also possible that he took the medications, ingested them and stashed them in the trash can.</p> <p>b. [Client H] broke into the med cabinet to take the meds out. There is no sign that the med cabinet was broken into. The lock to the med cabinet is still intact</p>			

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	<p>and the key locks the cabinet when engaged.</p> <p>c. [Staff #5] Overdosed [client H]. Staff [staff #5] says he never passed anyone's medications on this day...</p> <p>d. [Client H] was left unconscious outside of the house for 2 hours. Staff stated that there was no time when [client H] was left unmonitored except the time when he napped for a few minutes Staff stated also that [client H] was never unconscious and did not fall at all that day. [Client H] helped carry the groceries into the house, cleaned the kitchen and the dining room area sometime after dinner, [client H] also went with staff to pick a housemate from the [name of police department.].</p> <p>5. Staff delayed getting advanced medical assistance for [client H]. (His mother claims that [client H] was only taken in at 11pm). [Client H] started showing signs of not feeling well after coming back from picking up housemate from the came of [police department]. [Client H was back at the house around 9:15 PM and 911 was called a few moments after getting to the house when it was confirmed that he had taken the meds...."</p>			

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	<p>The facility's 3/17/15 to 3/25/15 investigation indicated "It is unclear when [client H] could have had access to his medications, when he took them out of the med cabinet, when and how many pills he ingested.. In order for [client H] to have access the medications, he would have accessed the keys if they were left somewhere unattended, he would have taken the meds after his last med pass before staff discovered they were missing or he would have climbed on a chair or desk to push his med tray down and had to pull the bubble packs one by one from the bottom of the medication cabinet. Staff members who had access to the keys on that day are: [staff #6] and [staff #3] who were the med passers and [staff #2] and [staff #5] who went to the food cabinet, and [staff #4] the med person who went into the med cabinet to check on the meds during the morning shift...The staff statements seem to provide a consistent story, the only thing against all this is the fact that [client H] was able to access his medications. V. Conclusion Based on Facts:</p> <p>a. [Client H] had access to his medications when no one was watching him.</p> <p>b. [Client H] also ingested some of his medications.</p> <p>VI. Actions</p>			

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	<p>a. Re-instate staff.</p> <p>b. Staff training on locking the med cabinet whenever they are not using it.</p> <p>c. '1:1 staffing' training for staff."</p> <p>The facility's 3/14 to 3/24/15 investigation indicated the facility failed to interview all facility staff who worked with the client to determine which clients could access the medication keys to get into the snack cabinet, to see if staff laid the keys down, and/or left the medication cabinet unlocked/medication room door open. The facility also failed to interview staff #7 in regard to their investigation as the staff worked on the morning shift on 3/17/15. The facility facility failed to interview clients to see if they witnessed anything in regard to medications and/or the keys on 3/17/15. The facility also failed to look at/describe the lay out of the house/environment during the investigation to determine how client H could get passed staff to access the medication room. The facility failed to obtain/include an actual interview with client H, client H's mother and/or obtain client H's hospital records in regard to the incident.</p> <p>During the 4/1/15 observation period between 5:41 AM and 7:20 AM, at the group home, there was one staff (staff #8) working at the group home at 5:41 AM.</p>			

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	<p>Staff #8 was assisting client G to shower. The office door was unlocked and open. The medication cabinet was locked. Client B was walking around the house and down the hallway back and forth where the medication door was open. Client E was packing a bag and carried it to the front of the house. When staff #1 arrived at the group home at 6:50 AM, the medication room door was still open. At 6:53 AM, client E went in the kitchen and retrieved a set of keys out of the drawer and went outside to the van as staff #1 went to the front door. Client E unlocked the van and placed a small overnight bag into the van. Client E then brought the set of keys back in the house and placed the keys in the kitchen drawer. The key ring had more than the van keys on the key ring. At 6:02 AM, staff #1 closed the medication room door but did not lock the door as staff #8 had the keys. At 6:05 AM, staff #1 obtained the keys from staff #8 and locked the office/med room door. Interview with client E on 4/1/15 at 6:12 AM indicated he knew the van key was on the ring, but he was not sure what the other keys were for.</p> <p>Client H's hospital records were reviewed on 4/1/15 at 8:45 AM. Client H's 3/17/15 Fire Department Patient Care Record (FDPCR) indicated the ambulance and</p>			

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	<p>emergency personnel arrived at the group home on 3/17/15 at 10:07 PM. The FDPCR indicated the chief complaint was "possible overdose."</p> <p>Client H's 3/17/15 Emergency Room (ER) Progress Note indicated client H arrived at the hospital at 10:33 PM. Client H's 3/17/15 Emergency/Urgent Care/Progress indicated client H "Got into medication and took an uncertain amount. The ER progress note indicated "...Pt (patient) brought in by fire department. Reported by medics the pt took a total of 25 pills in a combination of Seroquel, Keflex and pramipexole..."</p> <p>Interview with the PD and administrative staff #1 on 3/31/15 at 4:15 PM indicated the facility was not able to determine how client H got his medications. The PD and administrative staff #1 indicated the facility staff all indicated they kept client H in sight except when the client was in his room in bed. The PD and administrative staff indicated the facility staff all indicated the medications were locked and staff had the keys on their person. Administrative staff #1 and the PD stated "Had to happen when taking nap and went into med room" while staff was doing the laundry. The PD indicated client H had one on one staffing at the time of the incident. The PD stated the</p>			

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	<p>one on one staffing meant "Line of sight." Administrative staff #1 stated the facility completed its investigation of the 3/17/15 incident "last Friday (3/27/15). The PD and administrative staff #1 indicated they were not able to interview client H as he was in the hospital. The PD and administrative staff #1 indicated the facility's investigation did not indicate/include environmental factors of where client H's bedroom was in relation to the medication room. The PD indicated he did look at the environment during the investigation. The PD indicated client H would have to pass through the kitchen to get to the medication room. The PD indicated one staff was in the laundry room, one in the kitchen and one staff was gone on with 2 clients on an outing/in the community. Administrative staff #1 and the PD indicated the facility did not interview any clients and did not interview all staff who worked at the group home. Administrative staff #1 and the PD indicated they did not obtain and/or review client H's hospital records from the 3/17/15 hospitalization as part of their investigation. Administrative staff #1 indicated since client H went home with his mother, the facility could not obtain the hospital records.</p> <p>Interview with the PD on 4/1/15 at 12:15</p>			

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	<p>PM and at 4:55 PM indicated client H was not found by the garbage can on 3/17/15. The PD indicated this was the first he had heard of that. The PD indicated the interviews indicated client H was in the house when staff noticed he was having some problems and called the nurse, the PD and the doctor and then 911. The PD stated "[Client H's] being found by garbage cans was a mistake. Hospital misunderstood what staff said. The pills were found in the garbage, not the client by the garbage."</p> <p>Interview with staff #6 on 3/31/15 at 6:30 PM indicated he had worked on 3/17/15. Staff #6 indicated he had the keys on his person/carried them on his arm, and the medication cabinet was locked. Staff #6 stated when he went to administer client H's evening meds, the client's "meds were missing from the closet." Staff #6 indicated there were 25 pills missing from the client's bubble pack. Staff #6 stated "There was someone monitoring him. Never out of sight. He was to be in line of sight." Staff #6 stated "He was not happy here. Kept saying he wanted to go home." Staff #6 indicated client H had made 2 attempts at suicide. Staff #6 indicated one attempt was with a knife when client H indicated he would kill himself and threatened to cut his throat.</p>			

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	<p>Staff #6 indicated he did not know how client H was able to get his medications.</p> <p>Interview with staff #5 on 3/31/15 at 6:45 PM indicated he worked on 3/17/15 from 3 PM to 9 PM. Staff #5 indicated he did not see client H go into the medication room. Staff #5 indicated he did transport when he came in and then monitored client H when he returned. Staff #5 stated "He stayed with me. He cleaned dining room and then went to lay on his bed." Staff #5 stated "He checked on him 15 minutes and he was laying in bed but not asleep." Staff #5 indicated when client H got up he went outside and staff #5 followed him. Staff #5 indicated client H stayed outside for 45 minutes before returning to the house and sat in living room. Staff #5 indicated he went to assist client C with his shower and staff #6 monitored the client while he was gone. Staff #5 indicated he thought client H took a nap for 15 to 30 minutes. Staff #5 stated "Not unusual to take a nap." Staff #5 stated client H did not want to be at the group home, and client H would state "He would say he would kill himself."</p> <p>Interview with staff #1 on 3/31/15 at 7:00 PM stated client H was "Nice young man but he seemed to have some mental issues." Staff #1 indicated the client had</p>						

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	<p>pulled a knife on others when he first came to the group home. Staff #1 stated "He wanted everything his way." Staff #1 stated "He would hear voices that told him to do things. He would go after other clients. They would have to run to their rooms." When asked if client H had suicidal tendencies, staff #1 stated "Suicide was not one of them. He was more threatening to others than himself. He would threaten to kill himself if he could not go home." Staff #1 indicated client H had one on one staffing as the client had a staff assigned to him. Staff #1 stated the staff assigned to him may have more than one other client to assist, but if client H started to have behaviors, "He had one on one." Staff #1 indicated she worked on 3/17/15 but she was gone most of the time grocery shopping or taking a client to and from a class. Staff #1 indicated she worked the evening shift and for 4 hours in the morning. Staff #1 indicated the medication cabinet was locked and staff had the keys on their person. Staff #1 indicated staff #6 told her client H's medications were missing. Staff #1 indicated she took client H with her to pick up client E. Staff #1 indicated when they returned client H became upset when he overheard staff talking about the missing medications. Staff #1 indicated she talked with client H about the missing medications and client H indicated he</p>			

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	<p>took the medications and took 7 of the pills. Staff #1 indicated client H did not know which ones he took. Staff #1 indicated client H had told her he got the medications on the day shift. Staff #1 stated client H was "sluggish, slurring speech and lethargic". Staff #1 indicated the nurse was called and 911. Staff #1 indicated she was the staff who went to the hospital with the client. Staff #1 stated client H was "very sleepy at the hospital." Staff #1 indicated she did not how client #1 was able to obtain his medications.</p> <p>Interview with staff #8 on 4/1/15 7:10 AM and on 4/2/15 at 11:52 AM, by phone, indicated staff #8 did not work on 3/17/15. Staff #8 indicated facility staff would sometimes lay the medication key ring down to do some paperwork, but the staff were in the office area/med room. Staff #8 indicated the facility staff would pick up the keys and take them when they were leaving the office area. Staff #8 indicated the van keys were kept in the kitchen drawer. When asked what keys were on the van key, staff #8 indicated the van key was on the key ring and a key which went to a locked box that contained the workshop medications in it. Staff #8 indicated the locked box was in the medication cabinet. Staff #8 indicated client H had a 12 noon</p>			

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	<p>medication in the box. Staff #8 was not sure what the others keys went to.</p> <p>Interview with staff #4 on 4/2/15 at 12:01 PM, by phone, indicated staff #4 worked from 7:15 AM to 3:20 PM on 3/15/15. Staff #4 stated he worked in the medication room "most of the day on 3/17/15." Staff #4 stated he worked in the room "putting stuff on the computer." Staff #4 stated "I had them (med keys) going in and out of med cabinet." Staff #4 indicated he would give them to staff #3 when staff #3 passed the medications. Staff #4 indicated client H did not come into the medication room except to get his medication and to ask to cut out a picture the client had drawn. Staff #4 indicated he cut the paper out for client H as the client was not to have any sharps. Staff #4 stated he had "no idea" how client H got the medications.</p> <p>Interview with administrative staff #2 and the PD on 4/2/15 at 12:20 PM indicated medications should be locked at all times except when staff were administering the medications. When asked when did client H fall and hit his head, the PD stated "We heard from his mother. It was the same day of the incident. There is no evidence he fell and hit his head." The PD indicated the facility did not interview staff in regard to which clients were</p>			

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	<p>allowed to use the medication keys to get into the snack cabinet.</p> <p>Interview with client H's mother on 4/6/15 at 10:58 AM, by phone, indicated client H told her about the missing medications. Client H's mother stated client H indicated "The medications were laying on the desk in the office unlocked. All staff were in the back living room watching TV." Client H's mother stated client H indicated "He walked in there and got meds and walked out the front door and threw the meds away." Client H's mother indicated client H indicated he took the meds before he went outside and threw the medications away. Client H's mother indicated client H fell while he was outside and hit his head on the driveway. Client H's mother indicated client H told her all 8 clients were home at the time this occurred.</p> <p>Interview with staff #2 on 4/7/15 at 8:55 AM, by phone, indicated she worked the night shift on 3/17/15. Staff #2 stated she came at 10 PM and client H was sitting on the couch holding the remote control "looking drowsy." Staff #2 indicated she asked client H why he was up and client H did not respond. Staff #2 stated "He just looked drowsy." Staff #2 indicated facility staff then told her what happened. Staff #2 indicated they were waiting for</p>			

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W 157 Bldg. 00	<p>the ambulance to get to the group home. Staff #2 indicated client H was not outside the group home when she came into work. Staff #2 indicated she also worked during the morning shift on 3/17/15. Staff #2 indicated she did not pass medications on 3/17/15. Staff #2 stated "We would have to monitor [client H] all the time. Can't leave [client H] by himself." Staff #2 indicated she did not see client H go into the office on the morning shift. When asked if she saw medications sitting out, staff #2 stated "No, never." Staff #2 indicated clients A and E were the only 2 clients who could use the med room key to access the snacks/food in a cabinet in the medication room. Staff #2 indicated facility staff would need to be present when the clients used the key.</p> <p>This federal tag relates to complaints #IN00169980 and IN00169949.</p> <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, interview and record review for 2 of 8 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to</p>	W 157	Staff were suspended pending the investigation into the 3/17/15 incident with Client H. Following the investigation staff were	05/10/2015			

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	<p>implement its recommended corrective actions/measures in regard to seeking counseling services for client A who was sexually assaulted. The facility failed to implement its corrective actions/measures in regard to retraining staff, who had been suspended prior to returning to work in regard to an incident involving client H.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, facility Generated Event Reports (GER-internal incident reports) and/or investigations were reviewed on 3/31/15 at 2:10 PM and on 4/2/15 at 12:05 PM. The facility's 3/17/15 reportable incident report indicated "On 3/17/2015 while staff were getting ready to administer [client H's] medications, they discovered that his medications were missing from the med (medication) cabinet. Staff looked everywhere for the medications and could not find the meds. [Client H] has been known for throwing things in the trash can and they checked the trash can and found the meds in the trash can inside a [name of store] plastic bag. There were some meds missing and when asked about it, [client H] told staff that he had taken his meds from the med cabinet earlier in the day. He also told staff that he took about 7 of the pills. Staff asked</p>		<p>removed from suspension on 3/27/15 and were given the retraining recommended by the investigation over the phone prior to returning to work. On 3/31/15 all staff that were suspended completed a formal retraining as scheduled.</p> <p>Client A was referred to a local mental health facility for counseling related to the incident that occurred on 2/6/15, however he did not start counseling. In conjunction with the corrective action for W0227, the Program Director/QIDP will follow up on the referral by 5/10/15 to ensure that Client A is scheduled for counseling to address issues related to the sexual assault that occurred and Client A's sexuality training needs.</p> <p>The Program Director/QIDP will be retrained by 5/10/15 that all staff returning to work following an investigation will receive formal, documented retraining as recommended in the investigation report. The Program Director/QIDP will also be retrained by 5/10/15 on the expectation that any corrective actions noted in an investigation report will be implemented as required and plans will be updated and all staff will be retrained per the recommendations to ensure the issue does not recur in the future. The Program Director/QIDP will</p>		

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	<p>him what he had done with the other medications and he said that he had thrown them away. A few minutes later [client H] started showing signs that he was not doing well. His breathing changed and he started sweating. The emergency number was called and police and ambulances attended the scene. [Client H] was taken to the ER (emergency room) at [name of hospital] where he was admitted. [Client H] is still admitted and is listed as 'stable.' The agency suspended all the staff members who worked on this day at this site. Staff members are required to keep the medications locked in the med cabinet and never leave the med cabinet keys where individuals can take and use them...The agency policies require staff members to lock medications and ensure that no one has access to the meds except with staff. Staff members will be retrained and appropriate disciplinary action will be taken for those who did not follow company policy."</p> <p>The facility's 3/17 to 3/24/15 investigation indicated the following:</p> <p>"a. The med cabinet was left unlocked sometime after 12pm on 3/17/15. While none of the staff persons at Oxford remember when [client H] was out of sight, it is clear that the individual was</p>		<p>send all investigation reports to the Area Director for review to ensure the investigation was thorough and the appropriate corrective measures have been outlined. The Area Director will monitor all incident reports filed externally to BQIS and all internal incident reports to ensure all issues requiring investigations have investigation reports completed.</p> <p>System wide, all Program Director / QIDPs have reviewed this standard and will ensure that this concern is being addressed at all Dungarvin ICF-IDs.</p>	

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	<p>alone for some time and that was the time that he took the medications from the med room to another location. It is possible that when he took the medications from the med room, he hid them somewhere for a while and ingested them later. It is also possible that he took the medications, ingested them and stashed them in the trash can.</p> <p>b. [Client H] broke into the med cabinet to take the meds out. There is no sign that the med cabinet was broken into. The lock to the med cabinet is still intact and the key locks the cabinet when engaged.</p> <p>c. [Staff #5] Overdosed [client H]. Staff [staff #5] says he never passed anyone's medications on this day...</p> <p>d. [Client H] was left unconscious outside of the house for 2 hours. Staff stated that there was not time when [client H] was left unmonitored except the time when he napped for a few minutes. Staff stated also that [client H] was never unconscious, and did not fall at all that day. [Client H] helped carry the groceries into the house, cleaned the kitchen and the dining room area sometime after dinner, [client H] also went with staff to pick a housemate from the [name of police department.].</p>			

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	<p>5. Staff delayed getting advanced medical assistance for [client H]. (His mother claims that [client H] was only taken in at 11pm). [Client H] started showing signs of not feeling well after coming back from picking up housemate from the came of [police department]. [Client H] was back at the house around 9:15 PM and 911 was called a few moments after getting to the house when it was confirmed that he had taken the meds...."</p> <p>The facility's 5/17/15 to 3/25/15 investigation indicated "It is unclear when [client H] could have had access to his medications, when he took them out of the med cabinet, when and how many pills he ingested.. In order for [client H] to have access the medications, he would have accessed the keys if they were left somewhere unattended, he would have taken the meds after his last med pass before staff discovered they were missing or he would have climbed on a chair or desk to push his med tray down and had to pull the bubble packs one by one from the bottom of the medication cabinet. Staff members who had access to the keys on that day are: [staff #6] and [staff #3] who were the med passers and [staff #2] and [staff #5] who went to the food cabinet, and [staff #4] the med person</p>			

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	<p>who went into the med cabinet to check on the meds during the morning shift...The staff statements seem to provide a consistent story, the only thing against all this is the fact that [client H] was able to access his medications. V.</p> <p>Conclusion Based on Facts:</p> <p>a. [Client H] had access to his medications when no one was watching him.</p> <p>b. [Client H] also ingested some of his medications.</p> <p>VI. Actions</p> <p>a. Re-instate staff.</p> <p>b. Staff training on locking the med cabinet whenever they are not using it.</p> <p>c. '1:1 staffing' training for staff." The facility's 3/14 to 3/24/15 investigation indicated the facility completed the investigation on 3/27/15 as the PD signed the investigation on 3/27/15.</p> <p>During the 3/31/15 observation period between 5:55 PM and 7:20 PM, at the group home, staff #1, #5 and #6, who had been suspended, were working with clients A, B, C, D, E, F and G.</p> <p>The facility's inservice records were reviewed on 3/31/15 at 5:22 PM. The facility's 3/20/15 Statement Of In-Service Training For Employees indicated 7 staff were trained in regard to Med</p>			

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	<p>Administration, med administration policy and "Med Key Security." The 3/20/15 inservice record indicated staff #1, #2, #3, #4, #5 and/or #6, who had been suspended, had not been retrained. The facility failed to retrain staff #1, #2, #3, #4, #5 and #6 as recommended.</p> <p>Interview with the PD and administrative staff #1 on 3/31/15 at 4:15 PM indicated client H was no longer living at the group home. Administrative staff #1 stated the facility completed its investigation of the 3/17/15 incident "last Friday (3/27/15)." Administrative staff #1 and the PD on 3/31/15 at 4:15 PM indicated facility staff were allowed to return to work on 3/27/15. The PD indicated facility staff, who had not been suspended, were retrained to monitor clients and to lock the medication cabinet on 3/20/15. The PD indicated he would need to train staff who had been suspended on 3/31/15. The PD and administrative staff #1 stated the facility put in place a "key form" facility staff were to sign when they started their shift and when they finished their shift. The PD indicated the form would indicate who had/was responsible for carrying the medication key.</p> <p>Interview with administrative staff #2 and the PD on 4/2/15 at 12:20 PM indicated medications should be locked at</p>			

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	<p>all times except when staff were administering the medications. The PD stated "I had a conversation with them (suspended staff) on 3/27/15 before they went to work." The PD indicated he did not have any written documentation the staff were formally retrained until 3/31/15 after the staff had returned to work.</p> <p>2. The facility's reportable incident reports and/or investigations were reviewed on 3/31/15 at 2:10 PM. The facility's 2/6/15 reportable incident report indicated "[Client A] called the agency's supervisor on call on Friday February 6, 2015 to report that while using the bathroom at Day Program at (sic) one of his peers came from behind, lowered his pants and underwear, and sexually assaulted him. [Client A] informed the on call supervisor that he did not report this incident to his supervisor at day program because the individual who assaulted him was standing next to the supervisor. [Client A] claimed that when he got home after the incident, he excreted blood from his anus and experienced some pain. [Client A] was immediately sent to the ER (emergency room) where he was checked and they found some tearing in the anal cavity. Police officers interviewed [client A] who gave them the name of the peer he</p>				

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	<p>accused of sexually assaulting him. The attending physician prescribed 2 medications for [client A] to combat the possibility of him contracting a sexually transmitted disease (STD). The prescribed medications are: Lopinavir Ritonovir 500mg (milligrams), 2 tablets 2 times daily and Truvada 200 mg. 1 tablet once daily, and he is to take these medications for 26 days. [Client A] will have to see an infection control doctor within a week, [client A] will also need to get some labs done by 2/10/15 to check on the new medication he is taking. The team continues supporting [client A] encouraging him to report issues as soon as they happen. The team will also follow the physician's instructions to ensure that [client A] does everything, including med (medication) administration and appointments accordingly."</p> <p>The attached 2/13/15 Day Program Investigative Report indicated the day program became aware of the incident on 2/9/15 as the incident had occurred on 2/6/15 at their facility. The day program's investigation indicated "XX (perpetrator) reported that [client A] approached him and initiated the physical contact that the two of them had in the bathroom stall. XX reported [client A] was a willing participant. 1. [Client A]</p>			

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	<p>reported that XX approached him without his consent and that he was not a willing participant in the physical activity in the bathroom stall. XX appeared to be forthcoming in when describing the incident and providing details. [Client A's] account of the incident matched XX's in the physical contact description but that it was unwanted. [Client A's] answers became more vague when specific questions were posed to him regarding his responses to the incident, when his residential staff were notified, and why almost 5 hours passed before a staff person was notified. It is clear that something happened in the bathroom staff during the afternoon transport time and involved sexual contact. It is unclear as to whether both parties gave consent as it is [client A's] word against XX and XX's word against [client A]. There were no other known witnesses to this incident. As a result, it could not be determined if XX sexually assaulted [client A]. It could not be determined if [client A] consented to the physical interaction of a sexual nature with XX. Therefore, the allegation of sexual assault was unsubstantiated...."</p> <p>The day program's 2/13/15 investigation indicated the following Corrective Action the day program put in place (not all inclusive):</p>			

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	<p>"1. Per the Director of Employment Services, the process has already started in adding additional staff to the Employment Services department. This will aide (sic) in the prevention of inappropriate behavior in the workshop setting and provide more monitoring of clients in their work groups, in the bathroom and during break time in effort to provide productive, healthy and safe interactions.</p> <p>2. Per the Director of Employment Services, the break time, cafeteria and bathroom monitoring protocol and staff assignments will be reviewed and revised, as appropriate, to ensure all clients areas and venues are monitored consistently providing safe environments...."</p> <p>The facility's 2/13/15 investigation indicated "...IV. Findings of Fact: Based on the witness statements, these individuals do have some relationship. [Client A's] mother and the Oxford team have on several occasions cautioned [client A] about calling or receiving calls from [name of perpetrator], who has made it clear that he wants a romantic relationship with [client A]. Also, in 2014, there was an incident at [name of workshop] when both individuals agreed</p>			

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	<p>that it was consensual. V. Conclusion Based on Facts: 1. [Client A] was assaulted by [name of perpetrator]. 2. The rules, protocols and policies regarding client protection in bathrooms at day program are not clear as the interviewed staff contraindicated (sic) each other. 3. These individuals just happen to be in different groups at work, not because they are being separated. VI. Actions 1. The Program Director will arrange for counseling for him to be able to deal with the situation...."</p> <p>Client A's record was reviewed on 4/1/15 at 3:08 PM. Client A's 3/2/15 IDT note indicated "[Name of day program] has a safety contract to help [client A] stay safe...." Client A's IDT note indicated the following (not all inclusive):</p> <ul style="list-style-type: none"> "-There was no-one monitoring the guys when this happened. -[Name of day program] promises to have more staffing to monitor the individuals. -Mom is upset that [client A] had to go through this... -[Name of day program] will rearrange the work floor to make it easy for the supervisors to see what everyone is doing. It will be groups of 10. -[Client A] wants to get back to work... -[Client A] will have a different 			
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W 227 Bldg. 00	<p>supervisor and will continue doing the same jobs that he was doing with supervisor [day program supervisor #2].</p> <p>-[Client A] and [name of perpetrator] are no longer in close groups...</p> <p>-[Name of perpetrator] will have staff accompanying him to the bathroom.</p> <p>-[Client A] starts back to work on 3/3/15."</p> <p>Client A's record and/or 3/2/15 IDT indicated the facility failed to ensure client A received counseling in regard to the sexual assault and/or any other sexual issues as recommended by the facility's corrective actions.</p> <p>Interview with the PD on 3/31/15 at 2:40 PM indicated when asked if client A was receiving counseling, the PD stated "We are trying to get that for him now. The team met and recommended."</p> <p>This federal tag relates to complaints #IN00169980 and #IN00169949.</p> <p>9-3-2(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p>			

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	<p>Based on interview and record review for 1 of 4 sampled clients (A) and for 1 additional client (H), the clients' interdisciplinary team (IDT) failed to address the clients' identified training needs.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, facility Generated Event Reports (GER-internal incident reports) and/or investigations were reviewed on 3/31/15 at 2:10 PM and on 4/2/15 at 12:05 PM. The facility's reportable incident reports, GERs and/or investigations indicated the following (not all inclusive):</p> <p>-1/13/15 "On 1/13/2015, [client H] came home from doctor's appointment and started pacing up and down near the kitchen. [Client H] is a new individual and was admitted to this house two weeks ago. [Client H] has a history of tantrums, emotional outbursts, property damage, physical aggression and self injurious behavior...." The 1/13/15 reportable incident report indicated [client H] retrieved a knife and made threats toward others in the group home and threatened to kill himself and his family as the client did not want to live at the group home. The 1/13/15 reportable incident report indicated "...Staff</p>	W 227	<p>Client H is no longer served by Dungarvin. The behavior support plan that was in place at the time of his hospitalization was provided to Dungarvin by his behavior specialist upon him entering services with Dungarvin in January 2015 and it did not contain information related to a history of self-injurious behavior. Information related to a history of SIB was never included in any collateral information provided to Dungarvin during his transition.</p> <p>In conjunction with the corrective action for W0312, the Program Director/QIDP will be retrained on the expectation that the individuals' IPPs and BIPs include the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment. The QIDP will review all individuals' IPPs and ensure these training objectives are present, and if not, the QIDP will, in cooperation with the IDT, develop and implement specific training objectives for the person served. Specifically, the Program Director/QIDP will update the Sexuality Assessment Tool for Client A to identify his sexuality training needs. Client A's BIP currently addresses a targeted behavior of inappropriate sexual conduct and includes objectives related to this targeted behavior.</p>	05/10/2015	

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	<p>managed (sic) deescalate the [client H's] behavior and also told him to let go of the knife...." The reportable incident report indicated "...There is no need to be locking the knives at the mean time as it is not addressed in him behavior plan (sic). Staff is closely monitoring [client H's] behaviors and his health...."</p> <p>-3/7/15 "On Saturday, March 7, 2015 at about 2:04pm, staff reported that [client H] took a knife and attempted to cut himself on the neck and on the arm. Staff tried to calm him and asked him to put the knife down and he refused. At that point, [client H] threatened to harm everybody at the group home with the knife. Staff removed other individuals for safety and called 911. Staff followed protocol and informed the Program Director on call....Staff tried to deescalate and calm [client H] down but he threatened to harm himself and others. Staff called the police for safety. The police came to the group home and asked [client H] to drop the knife and he refused. Police then tasered him and cuffed him. Police transported [client H] to [name of hospital]. [Client H] was later admitted at [name of behavioral center] at around 6pm. The Program Director (PD) followed the police to [name of hospital] and later [name of behavioral center]. [Client H] is</p>		<p>The IPP will be updated to include information of Client A's history of vulnerability to sexual misconduct of others and an objective will be implemented to ensure his needs for training in this area are addressed. Client A was referred to a local mental health facility for counseling related to the incident that occurred on 2/6/15, however he did not start counseling. The Program Director/QIDP will follow up on the referral by 5/10/15 to ensure that Client A is scheduled for counseling to address issues related to the sexual assault that occurred and Client A's sexuality training needs.</p> <p>System wide, all Program Director / QIDPs have reviewed this standard and will ensure that this concern is being addressed at all Dungarvin ICF-IDs.</p>	

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	<p>currently admitted at [name of behavioral center]. The team will continue to ensure [client H's] health and safety at all times."</p> <p>-3/17/15 "On 3/17/2015 while staff were getting ready to administer [client H's] medications, they discovered that his medications were missing from the med (medication) cabinet. Staff looked everywhere for the medications and could not find the meds. [Client H] has been known for throwing things in the trash can and they checked the trash can and found the meds in the trash can inside a [name of store] plastic bag. There were some meds missing and when asked about it, [client H] told staff that he had taken his meds from the med cabinet earlier in the day. He also told staff that he took about 7 of the pills. Staff asked him what he had done with the other medications and he said that he had thrown them away. A few minutes later [client H] started showing signs that he was not doing well. His breathing changed and he started sweating. The emergency number was called and police and ambulances attended the scene. [Client H] was taken to the ER (emergency room) at [name of hospital] where he was admitted. [Client H] is still admitted and is listed as 'stable.' The agency suspended all the staff members who worked on this day at this site. Staff</p>			

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	<p>members are required to keep the medications locked in the med cabinet and never leave the med cabinet keys where individuals can take and use them...The agency policies require staff members to lock medications and ensure that no one has access to the meds except with staff. Staff members will be retrained and appropriate disciplinary action will be taken for those who did not follow company policy."</p> <p>Client H's hospital records were reviewed on 4/1/15 at 8:45 AM. Client H's 3/7/15 History and Physical (H & P) indicated "...The patient is said to have had suicidal ideation for a long time. He has been attempting suicide recently. Recently, he wanted to cut his throat with a knife and was tazed (sic) by the police, sent to [name of behavioral center] for about 36 hours and discharged. Then he overdosed on his medications. He was said to have stolen many pills of Seroquel, Mirapex and Keflex. It is unclear whether he swallowed these pills...."</p> <p>Client H's 3/20/15 Discharge Summary indicated client H's discharge diagnoses included, but were not limited to, "1. Drug Overdose. 2. Suicidal intent. Other Problems: 1. Developmental delay. 2. Cognitive deficits. 3.</p>			

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	<p>Depression...."</p> <p>Client H's record was reviewed on 4/1/15 at 1:58 PM. Client H's record indicated the following pre-admission paperwork:</p> <p>-12/30/14 Fax from an Outpatient Behavioral Health note which indicated a list of client H's current medications (Ativan-anxiety, Pramipexole-Depression, Quetiapine-Depression/Bipolar Disorder) and a summery of the client's hospitalization. The note indicated client H was hospitalized due to a "Mood problem." The 12/30/14 note also indicated "...You will be transported home per your mother with all your personal belongings. A person from Dunn Garvin (sic) will pick you up tomorrow to transport you to the group home. If you begin to have thoughts of hurting yourself and/or thought of hurting others please call 911 or report to your nearest emergency room."</p> <p>-12/22/14 History note indicated client H had a diagnosis of Suicidal Ideation as of 5/30/14 to the present and a diagnosis of Major Depression as of 9/27/14 to the present.</p> <p>-1/18/14 Individual Support Plan (ISP) from when client H lived at home with</p>			

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	<p>his mother, indicated client H's diagnoses included, but were not limited to, Pervasive Developmental Disorder, Bipolar Disorder, Obsessive Compulsive Disorder and Autism.</p> <p>Client H's 1/23/15 initial Psychiatric Consultation indicated "This is [client H's] first appointment with [name of psychiatrist]. [Client H] has been having some behavioral difficulties, and his main complaint is that he wants to go back and live with his mother. [Client H] gets really angry when he calls his mother and she does not pick the phone and this usually starts other behaviors for him (sic)." The 1/23/15 consultation form indicated client H received the following behavioral/psychiatric medications:</p> <p>-Escitalopram 20 mg daily for Depression and Obsessive Compulsive Disorder...."</p> <p>-Quetiapine (Seroquel) 300 mg daily at bedtime for Bipolar Disorder.</p> <p>Client H's undated Behavioral Intervention Plan (BIP) indicated client H demonstrated the following targeted behaviors:</p> <p>-Anger Response -Physical Aggression -Verbal Aggression</p>			

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	<p>-Property Mishandling/Destruction.</p> <p>Client H's 1/2/15 Individual Support Plan (ISP) indicated "[Client H] moved into the Dungarvin Oxford Group Home on 01/02/2015. [Client H] is diagnosed with Mild mental retardation, epilepsy, pervasive developmental disorder, bi-polar disorder, obsessive compulsive disorder and autism...."</p> <p>Client H's undated Interdisciplinary Team Meeting (IDT) (hand written notes) indicated the client's IDT met to discuss client H's 3/7/15 knife incident. The undated IDT note indicated the following (not all inclusive):</p> <p>"-...Staff couldn't do DCI (restraint technique) because he had a weapon. -Staff members were asked to move away by the police. -Its never been an issue. -Mom- he pulled a knife before & staff called me- Why not now? -HRC (Human Rights Committee) approved to lock sharps. -Nothing in BIP or high risk plan about informing the police about the VNS (Vagal Nerve Stimulator) and any kind of interaction... -Mom -he won't stop until he gets what he wants. -BDDS concern that he was hospitalized</p>			

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	<p>so many times & APS got involved. How are things going to be different this time.</p> <p>-Mom- I want what is best for him, but I don't want him tasered...</p> <p>-[Client H's] mom has arrangements made-[Client H] will live in his sister's basement.</p> <p>-[Client H's] family lives near a police station, when he gets angry he would walk to the PD (police department) & tell them he wanted to kill himself & they would take him to [name of hospital].</p> <p>-Mom claims between her & other family members, [client H] will have round the clock care...."</p> <p>Client H's undated BIP, ISP and/or undated IDT note indicated the facility failed to clearly define/address client H's Depression/Bipolar Disorder and/or address client H's suicide attempts/suicide ideations.</p> <p>Interview with the PD and administrative staff #1 on 3/31/15 at 4:15 PM indicated client H was no longer living at the group home. The PD and administrative staff #1 indicated client H did not have a history of suicide attempts until the 3/17/15 incident with trying to cut himself with a knife. The PD indicated client H was not suicidal when he entered the group home as there was no</p>			

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	<p>documentation of suicides/suicidal ideation. The PD indicated he was not aware of the pre-admission paperwork in client H's record which indicated the client had a history of suicidal ideation and depression. Administrative staff #1 indicated she did not know where the former PD got the information in regard to self-injurious behavior from as indicated on the 1/15/15 reportable incident report when he threatened others with a knife. The PD indicated client H had been on all his behavioral medications prior to coming to Dungarvin. The PD indicated he was not sure what symptoms client H demonstrated in regard to the client's Bipolar Disorder.</p> <p>Interview with administrative staff #2 and the PD on 4/2/15 at 12:20 PM indicated client H's IDT met after the 3/7/15 incident with the knife and hospitalization. The PD indicated client H's mother had decided to take the client home after the IDT meeting so the IDT did not address the client's suicide attempts/behavior and/or threats. The PD indicated when the client did not go home, the team did not reconvene to address the client's identified behavioral needs.</p> <p>2. The facility's reportable incident</p>			

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	<p>reports and/or investigations were reviewed on 3/31/15 at 2:10 PM. The facility's 2/6/15 reportable incident report indicated "[Client A] called the agency's supervisor on call on Friday February 6, 2015 to report that while using the bathroom at Day Program at (sic) one of his peers came from behind, lowered his pants and underwear, and sexually assaulted him. [Client A] informed the on call supervisor that he did not report this incident to his supervisor at day program because the individual who assaulted him was standing next to the supervisor. [Client A] claimed that when he got home after the incident, he excreted blood from his anus and experienced some pain. [Client A] was immediately sent to the ER (emergency room) where he was checked and they found some tearing in the anal cavity. Police officers interviewed [client A] who gave them the name of the peer he accused of sexually assaulting him...."</p> <p>The attached 2/13/15 Day Program Investigative Report indicated the day program became aware of the incident on 2/9/15 as the incident had occurred on 2/6/15 at their facility. The day program's investigation indicated "XX (perpetrator) reported that [client A] approached him and initiated the physical contact that the two of them had in the</p>			
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	<p>bathroom stall. XX reported [client A] was a willing participant. 1. [Client A] reported that XX approached him without his consent and that he was not a willing participant in the physical activity in the bathroom stall. XX appeared to be forthcoming in when describing the incident and providing details. [Client A's] account of the incident matched XX's in the physical contact description but that it was unwanted. [Client A's] answers became more vague when specific questions were posed to him regarding his responses to the incident, when his residential staff were notified, and why almost 5 hours passed before a staff person was notified. It is clear that something happened in the bathroom stall during the afternoon transport time and involved sexual contact. It is unclear as to whether both parties gave consent as it is [client A's] word against XX and XX's word against [client A]. There were no other known witnesses to this incident. As a result, it could not be determined if XX sexually assaulted [client A]. It could not be determined if [client A] consented to the physical interaction of a sexual nature with XX. Therefore, the allegation of sexual assault was unsubstantiated...."</p> <p>The day program's undated witness statement by the day program's workshop</p>			
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	<p>supervisor #1 indicated "...There is no supervision in the bathrooms. [The name of the perpetrator] has made allegations about other individuals doing the same thing to him in the past...." The undated witness statement indicated "...7. What is your understanding of the history of the relationship between [client A] and [name of perpetrator]? These two are always on and off. Over the past couple of weeks, [the name of perpetrator] was obsessing about another individual. I did not know what he was saying about [client A]. [The name of perpetrator] focuses on an individual and some tell him that, they would never be his partner, and when that happens, he falls on [client A] who is always available for him...."</p> <p>An undated witness statement by day program supervisor #2 indicated client A and the perpetrator had a history of calling each other outside of the day program. Supervisor #2's undated witness statement indicated "...What is your understanding of the history of the relationship between [client A] and [name of perpetrator]? [Client A] has approached me 2-3 times talking about [name of perpetrator] approaching him, but I haven't heard anything else...."</p> <p>An undated witness statement by the day program's Program Coordinator (PC)</p>			

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	<p>indicated "...Have you noticed any romantic and or threatening interactions between [name of perpetrator] and [client A] in the past especially recently? Not that I know of. [Name of perpetrator] likes exaggerating things. Recently he said that he and [client A] were going out, but as far as I know, that is not true...."</p> <p>The facility's 2/13/15 Investigation Report indicated the incident happened around 3:00 PM on 2/6/15 when it was time for the clients to leave the workshop. The investigation also indicated "...These two individuals have in the past accused each other of calling each other, and [client A's] guardian has, on several instances, instructed the individuals to stop calling or interacting with each other for sexually (sic) reasons, and has also blocked [name of the perpetrator's] phone from calling [client A's] phone. Despite all these attempts by his guardian to stop any communication between the two individuals, [client A] continued calling [name of perpetrator] and would go to the extent of using 'collect calls' to get through to [name of perpetrator]. This incident was reported to the state and both Dungarvin and [name of workshop] initiated separate investigations into the matter...." The facility's investigation indicated the</p>			

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	<p>workshop's "...findings are inconclusive as the individuals are pointing fingers at each other concerning who initiated it..."</p> <p>The facility's investigation also indicated "...[Client A] also informed the PD on 2/13/15 that sometime in 2014 he and [name of perpetrator] had engaged in some sexual act at one of the [name of day program's] bathrooms and that before that nothing like that had happened. [Client A] also states that he does not like what [name of perpetrator] did to him and is afraid that this could happen again, but wants to go back to work...."</p> <p>The facility's 2/13/15 investigation indicated "...IV. Findings of Fact: Based on the witness statements, these individuals do have some relationship. [Client A's] mother and the Oxford team have on several occasions cautioned [client A] about calling or receiving calls from [name of perpetrator], who has made it clear that he wants a romantic relationship with [client A]. Also, in 2014, there was an incident at [name of workshop] when both individuals agreed that it was consensual. V. Conclusion Based on Facts: 1. [Client A] was assaulted by [name of perpetrator]...."</p> <p>Client A's record was reviewed on 4/1/15 at 3:08 PM. Client A's 2/7/15 Emergency Department (ED) Discharge Instructions</p>			

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	<p>indicated "Diagnosis: Anal tear, Sexual assault." The ED discharge instructions indicated client A was given "patient Education" in regard to sexual assault and rape.</p> <p>Client A's 11/21/14 Sexuality Assessment Tool indicated indicated the following (not all inclusive):</p> <p>Scored 3 "Needs close supervision, instruction, or intensive programming. Performs less than 50% of the time."</p> <p>- "Recognizes the need for self protection from strangers."</p> <p>- "Understands the many possible relationships between men and women, i.e. (example), dates, friends, brotherly."</p> <p>- "Recognizes or identifies homosexual/lesbian intimacy."</p> <p>- "Recognizes and understands health consequences of homosexual/lesbian intimacy."</p> <p>Scored 4 "Not able to complete. Lacks skills or ability."</p> <p>- "Recognizes/identifies inappropriate forced sexual acts, i.e., rape in the form of oral, anal and vaginal sex."</p> <p>- "Identifies appropriate homosexual/heterosexual social activities."</p>			

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	<p>- "Recognizes and understands health consequences of heterosexual intimacy." The sexuality assessment indicated "... [Client A] has the very basic skills" in regard to human sexuality. The assessment indicated "...He needs a lot of information concerning that area...." The assessment indicated client A would be vulnerable to sexual exploitation by others. Client A's 11/21/14 Sexuality Assessment Tool, in the area entitled "Identified Problems/Needs:," was blank. The facility failed to identify client A's sexuality training needs.</p> <p>Client A's 11/21/14 Informed Consent Assessment indicated the following (not all inclusive):</p> <p>Scored 2 ("Most often true. Needs staff guidance, reminder or prompts. Performs more than 50% of the time.)"</p> <p>- "Retreats from potentially abusive situation." - "Identifies manipulation by others."</p> <p>Scored 3 ("Needs close supervision, instruction, or intensive programming. Performs less than 50% of the time.)"</p> <p>- "Understands sexual abuse prevention techniques."</p>			

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	<p>Client A's 11/21/14 ISP indicated client A's IDT did not address the client's identified training needs in regard to sexuality/vulnerability.</p> <p>Interview with administrative staff #1 and the PD on 3/31/15 at 4:15 PM indicated client A was sexually assaulted while at his day program.</p> <p>Interview with client A on 4/1/15 at 10:16 AM indicated client A did not want the other client to perform the sex act. Client A indicated the perpetrator had not touched the client since the 2/6/15 incident occurred. Client A stated "I don't want to be his friend anymore."</p> <p>Interview with the PD on 4/2/15 at 12:20 PM indicated there had been a history with the clients. The PD indicated since the 2/16/15 incident, client A had sent the other client text messages which the workshop noticed and shared with the facility. The PD stated the text messages were "not appropriate." The PD stated in a past incident, client A was the aggressor as the other client reported "[client A] attacked him." The PD indicated the other client ended up saying it was consensual. The PD indicated client A's ISP did not address the client's sexuality training needs/vulnerability.</p>			

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W 312 Bldg. 00	<p>This federal tag relates to complaint #IN00169194, #IN00169980 and #IN00169949.</p> <p>9-3-4(a)</p> <p>483.450(e)(2) DRUG USAGE</p> <p>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. Based on interview and record review for 1 additional client (H), the facility failed to ensure the psychotropic medications had an active treatment program which specifically address the client's behavioral needs.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, facility Generated Event Reports (GER-internal incident reports) and/or investigations were reviewed on 3/31/15 at 2:10 PM and on 4/2/15 at 12:05 PM. The 3/17/15 facility's reportable incident report "On 3/17/2015 while staff were getting ready to administer [client H's] medications, they discovered that his medications were missing from the med (medication) cabinet. Staff looked everywhere for the medications and could</p>	W 312	Client H is no longer served by Dungarvin. The behavior support plan that was in place at the time of his hospitalization was provided to Dungarvin by his behavior specialist upon him entering services with Dungarvin in January 2015. Information related to a history of suicidal ideation was never included in any collateral information provided to Dungarvin during his transition, and was included only on a discharge summary that was received by the Dungarvin nurse and was not shared with the Program Director / QIDP and/or other members of the IDT. The nurse will be retrained by 5/10/15 that all discharge summaries will be reviewed as they are received and any pertinent information will be shared with the Program Director and/or IDT. The Behavior Intervention Programs for all individuals in the home will be	05/10/2015

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	<p>not find the meds. [Client H] has been known for throwing things in the trash can and they checked the trash can and found the meds in the trash can inside a [name of store] plastic bag. There were some meds missing and when asked about it, [client H] told staff that he had taken his meds from the med cabinet earlier in the day. He also told staff that he took about 7 of the pills. Staff asked him what he had done with the other medications and he said that he had thrown them away. A few minutes later [client H] started showing signs that he was not doing well. His breathing changed and he started sweating. The emergency number was called and police and ambulances attended the scene. [Client H] was taken to the ER (emergency room) at [name of hospital] where he was admitted...."</p> <p>Client H's hospital records were reviewed on 4/1/15 at 8:45 AM. Client H's 3/7/15 History and Physical (H & P) indicated "...The patient is said to have had suicidal ideation for a long time. He has been attempting suicide recently. Recently, he wanted to cut his throat with a knife and was tazed (sic) by the police, sent to [name of behavioral center] for about 36 hours and discharged. Then he overdosed on his medications. he was said to have stolen many pills of</p>		<p>reviewed by the QIDP by 5/10/15 to ensure that all current psychotropic medications and behavioral needs are addressed. Should any plan not address the behavioral needs of all persons served in the home the plan(s) will be revised and sent to guardian(s), IDTs, and the HRC for the required approvals. The current QIDP will be retrained on the expectation that all psychotropic drug usage and behavioral needs will be addressed in the Individual Program Plan through the Behavior Intervention Program. System wide, all Program Director / QIDPs have reviewed this standard and will ensure that this concern is being addressed at all Dungarvin ICF-IDs.</p>	

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	<p>Seroquel, Mirapex and Keflex. It is unclear whether he swallowed these pills...."</p> <p>Client H's 3/20/15 Discharge Summary indicated client H's discharge diagnoses included, but were not limited to, "1. Drug Overdose. 2. Suicidal intent. Other Problems: 1. Developmental delay. 2. Cognitive deficits. 3. Depression...."</p> <p>Client H's record was reviewed on 4/1/15 at 1:58 PM. Client H's record indicated the following pre-admission paperwork:</p> <p>-12/30/14 Fax from an Outpatient Behavioral Health note which indicated a list of client H's current medications (Ativan-anxiety, Pramipexole-Depression, Quetiapine-Depression/Bipolar Disorder) and a summery of the client's hospitalization. The note indicated client H was hospitalized due to a "Mood problem...."</p> <p>-12/22/14 History note indicated client H had a diagnosis of Suicidal Ideation as of 5/30/14 to the present and a diagnosis of Major Depression as of 9/27/14 to the present.</p> <p>-1/18/14 Individual Support Plan (ISP)</p>			

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	<p>from when client H lived at home with his mother, indicated client H's diagnoses included, but were not limited to, Pervasive Developmental Disorder, Bipolar Disorder, Obsessive Compulsive Disorder and Autism.</p> <p>Client H's 1/23/15 initial Psychiatric Consultation indicated "This is [client H's] first appointment with [name of psychiatrist]. [Client H] has been having some behavioral difficulties, and his main complaint is that he wants to go back and live with his mother. [Client H] gets really angry when he calls his mother and she does not pick the phone and this usually starts other behaviors for him (sic)." The 1/23/15 consultation form indicated client H received the following behavioral/psychiatric medications:</p> <p>-Escitalopram 20 mg daily for Depression and Obsessive Compulsive Disorder...."</p> <p>-Quetiapine (Seroquel) 300 mg daily at bedtime for Bipolar Disorder.</p> <p>Client H's undated Behavioral Intervention Plan (BIP) indicated client H demonstrated the following targeted behaviors:</p> <p>-Anger Response -Physical Aggression</p>			

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	<p>-Verbal Aggression -Property Mishandling/Destruction.</p> <p>Client H's 1/2/15 Individual Support Plan (ISP) and/or BSP indicated the facility failed to clearly define client H's Depression/Bipolar Disorder and/or failed to ensure the client had an active treatment program which addressed the specific behaviors for which the medications were prescribed.</p> <p>Interview with the PD and administrative staff #1 on 3/31/15 at 4:15 PM indicated client H did not have a history of suicide attempts until the 3/17/15 incident with trying to cut himself with a knife. The PD indicated client H was not suicidal when he entered the group home as there was no documentation of suicides/suicidal ideation. The PD indicated he was not aware of the pre-admission paperwork in client H's record which indicated the client had a history of suicidal ideation and depression. The PD indicated client H was admitted to the group home on the following psychotropic medications of Ativan, Pramipexole and Quetiapine.</p> <p>Interview with the PD on 4/1/15 at 12:15 PM and at 4:55 PM indicated he was not sure what symptoms client H demonstrated in regard to the client's</p>				

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	<p>Bipolar Disorder.</p> <p>Interview with the PD on 4/2/15 at 12:20 PM indicated client H's IDT met after the 3/7/15 incident with the knife and hospitalization. The PD indicated client H's mother had decided to take the client home after the IDT meeting so the IDT did not address the client's suicide attempts and/or threats to ensure the client had an active treatment program which addressed the behaviors for which the medications were prescribed.</p> <p>This federal tag relates to complaint #IN00169194, #IN00169980 and #IN00169949.</p> <p>9-3-5(a)</p>				