

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G658	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/23/2015
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NAME OF PROVIDER OR SUPPLIER  VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 3335 SANIBEL DR FORT WAYNE, IN 46815
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W 0000  Bldg. 00	<p>This visit was for a full recertification and state licensure survey. This visit included the investigation of complaint #IN00174697.</p> <p>Complaint #IN00174697: Substantiated, Federal/state deficiencies related to the allegations are cited at W149, W157 and W249.</p> <p>Dates of Survey: June 16, 17, 22 and 23, 2015.</p> <p>Facility number: 001195 Provider number: 15G658 AIM number: 100474580</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0149  Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, the facility failed for 1 of 3 sampled clients (client A) and 2 additional clients (clients F and H) to implement the facility's policies and procedures which prohibited abuse, neglect and exploitation. The facility failed to protect clients A and H from elopement (AWOL - Absent Without Leave). The facility failed to implement effective corrective action to protect client A from elopement behavior after a history of elopement had been identified. The facility failed to implement clients A and H's needs for supervision. The facility failed to protect client F from burns by client H.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports from 3/2015 through 6/2015 were reviewed on 6/17/15 at 2:58 PM and indicated the following:</p> <p>1. A BDDS report dated 5/27/15 indicated client A walked away from staff while shopping. Staff called the police and client A was found 2.5 miles away and returned to the group home. The report indicated client A has "excellent pedestrian safety skills and can</p>	W 0149	<p>W149: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. All staff will be retrained on Client A's BSP: specifically on his being within eyesight while in the community and in the home to protect him from going AWOL. The QIDP will be trained in completing a thorough investigation of any/all AWOLs that occur in the home which will include corrective action. Staff will be trained that the use of matches by any consumer is not allowed in the home. Consumers who use tobacco products will be assessed as to their ability to remain safe while smoking, including their ability to safely use and keep lighters on their person. Client H is no longer a consumer within our services. The QIDP will review all behavior data on a monthly basis and make recommendations for changes based on the data. All internal incident reports will be reviewed by the Clinical Supervisor weekly to assure that those needing an investigation have had one completed. Clinical Supervisor, Program Manager and Executive Director will review all investigations as they are</p>	07/23/2015

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	<p>keep himself safe." The report indicated client A's supervision level was increased to within eyesight while shopping.</p> <p>An investigation dated 5/29/15 into client A's elopement attached to the report indicated client A had left the store after being told the group home funds could not be used to purchase an individual soda for client A. Client A did not "look that upset and they continued to shop." Client A was following staff down the aisles, "When she turned around he was not in the aisle or by the cart." Police were called after a search of the store for client A and he was found by the police near an apartment complex. Client A indicated he "wanted a pop while at [store] and staff would not buy it. He said that staff always buys [client H] what he wants when they go out. He was upset so he left the store. He said that the police found him by some apartments and took him home." Staff #1 and #10 indicated "they do not purchase anything for an individual's use on [group home funds]." Staff #10 indicated they had purchased coffee and a bread as requested by client H as "it could be used by all the gentlemen in the home." Corrective action indicated elopement was added to client A's behavior plan and "staff will have [client A] within eyesight when in the community."</p>		completed, to assure that they are thorough and contain corrective action to prevent future occurrence.	

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	<p>Client A's record was reviewed on 6/17/15 at 4:25 PM. Client A's ISP (Individual Support Plan (ISP) dated 1/21/15 included a social history which indicated client A had graduated from high school with a diploma and had lived in an apartment alone in 2002 prior to unintentionally burning himself while smoking. Client A had a history of substance abuse and schizophrenia with noncompliance to take medications. Client A lived with family after being discharged from a mental health facility for noncompliance and moved into the group home on 2/22/12. The record indicated client A had a diagnosis of seizure disorder. "The IDT (interdisciplinary team) recommends that he have supervision while participating in community activities...[client A] has a history of non-compliance, over indulgence in caffeine, seeking revenge, and symptoms associated with schizophrenia (i.e., religious preoccupations, inappropriate sexual comments, in public naked, giving away possessions, etc.)." There was no evidence in the record client A had exhibited the identified history of symptoms of schizophrenia while living in the group home. The ISP indicated client A was "aware of possible dangers" (not specified).</p>			
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	<p>A Modification of Rights dated 1/21/15 indicated client A's freedom of movement was restricted to "areas of his home and the surrounding area supervised by staff. [Client A] will be supervised during activities within the community. When living with his [relative], [client A] left his home to get a pop at the gas station and returned with no problems."</p> <p>A Behavior Support Plan (BSP) dated 1/21/15 indicated target objectives of non-compliance, physical aggression, and leaving home without notification. "According to reports, [client A] left previous placements and family homes without notification when he wanted a pop. He has in the past walked to a local gas station and returned unharmed." The gas station named in previous incidents was located within 2 blocks of client A's group home. Interventions indicated "Be aware of [client A's] location every 5 minutes, and call the police if [client A] refuses to come home..." An addendum dated 6/1/15 indicated a target objective of "elopement (AWOL) (away without leave). [Client A] has demonstrated the ability to leave his home or staff in the community without notifying his residential staff. [Client A] has left staff supervision in the community while</p>						

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	<p>shopping and staff had to notify police, this action caused putting his safety at risk in the community (sic)."</p> <p>Interventions indicated "Residential staff should ensure they are walking behind [client A] in the community to ensure [client A] is present in the community."</p> <p>Additional BDDS reports and investigations of client A's elopement were reviewed on 6/23/15 at 11:50 AM.</p> <p>A BDDS report dated 8/29/14 indicated client A left the group home "without telling staff and was going to walk to a nearby gas station. Staff immediately followed [client A] down the street and convinced him to return to the home. He was not out of eyesight of the staff. He has a BSP for leaving the home and it was being followed. The QIDP (Qualified Intellectual Disabilities Professional) will review his BSP to see if there is need for any revision." The investigation dated 8/29/14-9/1/14 indicated client A did not want to wait for staff to go with him to the gas station, and staff immediately followed and remained with him the entire time he was out of the home. Findings indicated "15 minute checks were implemented in an attempt to keep [client A] safe."</p> <p>A BDDS report dated 9/20/14 indicated</p>			

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	<p>client A left the group home "unsupervised to get a pop at a gas station 2 blocks away. [Client A] was sitting on the front porch of the home: staff were completing their 15 minutes security checks on him. When staff went to do a check, he was not on the porch or in the home. Staff immediately went in the direction of the gas station and found [client A] walking back from the gas station with a pop." Corrective action indicated client A "will now be line of sight at the home and will have supervision if he wants to sit on the porch. It should be noted that [client A] has pedestrian safety skills and is aware of his environment and dangers in the community. [Client A] has walked to the gas station on numerous occasions. It is approximately 2 blocks away and there is a sidewalk all the way to the gas station." The investigation dated 9/25/14 indicated client A's plan had been changed to include 5 minute security checks and to keep client A within eyesight whenever outside his home." Client A "will have his own pop in the home."</p> <p>A BDDS report dated 12/4/14 indicated client A's roommate used an outlet he considered to be his and client A "became verbally aggressive and when staff attempted to redirect him, he pushed and swung at staff. When staff was unable to</p>			
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	<p>calm [client A] down, the police were called." Police arrived and talked to client A and left when they thought client A was calm. Client A then left the home and staff followed him. "After approximately 10 minutes, staff in the home called police for assistance. The police met up with [client A] and [staff #12] approximately one block from the home. [Client A] was escorted back to his home by the police." Corrective action indicated client A's IDT would meet and his plan was followed during the incident. The investigation dated 12/10/14 indicated client A "was upset about the use of an electrical plug located in his shared bedroom." Findings indicated staff would be trained on the importance of "appropriate word choice, voice tone, handling of power struggles, and interactions with clients." The IDT met and added physical aggression to client A's BSP, and client A was moved to a different bedroom.</p> <p>A BDDS report dated 1/25/15 indicated client A walked out of the group home with his hat and coat on and continued walking "despite staff requesting that he come back into the home. When it was apparent that [client A] was going to continue walking away, a staff member immediately followed him. He was within eyesight of the staff at all times.</p>			
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	<p>When he continued to walk and refused to come back to the home, the police were called to assist. The police returned [client A] and the staff to the home. Corrective action indicated the police "spoke with [client A] about leaving the home...AWOL is addressed in his BSP and the plan was being followed." There was no evidence of an investigation into the incident or of other corrective action.</p> <p>Client A's Comprehensive Functional Assessment (CFA) dated 6/9/14 indicated client A was independent in crossing the street by self, "obeys traffic signals and 'walk/don't walk' signs, looks both ways and waits as necessary before crossing the street...."</p> <p>The Program Manager of Supported Group Living (PMSGL) was interviewed on 6/22/15 at 3:10 PM and indicated client A had not eloped since January, 2015 until the incident on 5/27/15. She stated client A's plan was "further defined" after the incident on 5/27/15 where he left the grocery store and his plan had previously included leaving his home.</p> <p>The PMSGL was interviewed on 6/23/15 at 12:40 PM and indicated the incident of client A leaving the store placed him at risk, and stated, "But he was headed</p>			

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	<p>home. He has good pedestrian safety skills. At home he walked independently in the community, but mom is fearful he will have a seizure." The PMSGL indicated client A's elopement on 5/27/15 did not meet his supervision needs. She indicated she was unaware client A's plan had included the intervention for staff to keep him within eyesight at all times in the community at the time of his elopement on 5/27/15. She indicated she was unable to find evidence of an investigation or of corrective action into the incident of client A's elopement on 1/25/15.</p> <p>2. A BDDS report dated 4/3/15 indicated client H left the group home "around 10:00 PM by climbing out his bedroom window and walked approximately 2.5 miles to his mother's apartment. [Client H] was upset with a peer and staff member." Corrective action indicated client H's mother brought him back to the group home. "He has excellent pedestrian safety skills and it is in his plan that he is able to be away from the group home unsupervised, however it is time limited and staff are to be informed prior to his leaving. His BSP (Behavior Support Plan) will be reviewed and revised as needed." A follow up report dated 4/9/15 indicated client H's plan included "up to 15 minutes of unsupervised time away</p>			

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	<p>from home." Client H indicated client A went to client H's room and "was 'staring' at him. He yelled at [client A] to get out of his room and to quit staring. [Client A] stood in his doorway a little bit. [Client H] then said he went to [client A's] room and 'trashed' it. When asked what he did, he said he kicked [client A's] chair, turned up his radio, and pushed more stuff off his dresser. He said that [staff #6] told him that if he touched anyone she would call the police and his probation officer. This 'p-----' him off because he didn't want anyone calling his probation officer and she [staff #6] shouldn't have said that." After client H arrived at his mother's house, his mother attempted to contact a mental health facility for client H, "but they said he couldn't come there," and client H's mother returned him to the group home "about 11:30 pm." The conclusion indicated client H "will be on 5 minute security checks for the next 30 days, then he will be on 15 minute security checks...."</p> <p>Client H's record was reviewed on 6/22/15 at 3:35 PM. A BSP dated 1/2/15 indicated target objectives of physical aggression, self injury, trash picking (going through trash bins), hoarding property destruction and elopement. The BSP indicated client H had collected 2</p>			

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	<p>nonworking computers, taken them apart and put the parts back together to form a working computer. A Modification of Individual Rights dated 2/3/15 indicated client H "is able to go on the porch, in the yard, down the street on his bike, or down the street to the nearest gas station [name of gas station] with a 15 minute cap. [Client H] will be supervised during activities within the community. [Client H] is aware of possible dangers and does possess good pedestrian safety." A CFA dated 2/3/15 indicated client H was independent in pedestrian safety skills.</p> <p>The PMSGSL was interviewed on 6/23/15 at 12:42 PM and indicated client H's supervision needs weren't met when he eloped from the group home.</p> <p>3. A BDDS report dated 5/30/15 indicated client F "received two burns on the nape of his neck, one measuring 1/2 " (inches) in diameter, the other one 1/4 " in diameter. He received these burns when a peer, [client H] threw lit matches at his neck while the two were playing video games. As soon as staff became aware of the behavior, they attempted to take the matches away from [client H], but would would not give them to staff. He did put them away." Corrective action indicated staff would meet to discuss a modification of rights to possess</p>			

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	<p>lighters/matches, and client H would be within eyesight of staff when around peers until client H's team could meet. A follow up report dated 6/5/15 indicated client F's burns were second degree and were healing and scabbed over.</p> <p>An Investigative Summary attached to the report dated 6/3/15 indicated client H would have a restriction put into place regarding lighters/matches. An addendum to the investigation dated 6/3/15 indicated client H "went AWOL from the workshop on 6/1/15 and was subsequently aggressive with police. Since he had the incident over the weekend with a peer and the incidents on 6/1/15, it was decided to have him stay with his family until his move to his waiver home which was to be in a few days. He moved to his waiver home on 6/3/15."</p> <p>The PMSGGL was interviewed on 6/23/15 at 12:42 PM and indicated staff were unaware client H had the matches prior to the incident with client F and did not have a history of using matches. She indicated client H had a history of attempting to intimidate others and it was difficult to control his behavior.</p> <p>The facility's Policy/Procedure for Reporting and Investigating Abuse,</p>			

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	Neglect, Exploitation, and Mistreatment of clients dated 6/2011 was reviewed on 6/22/15 at 1:28 PM and indicated "All allegations or occurrences of abuse/neglect/exploitation/mistreatment shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of ResCare Northern Region Indiana, local, state and federal guidelines...Procedures: 1. Any ResCare staff person who suspects an individual is the victim of abuse/neglect/exploitation should immediately notify the Director of Supported Group Living (group homes), then complete an Incident Report. The Director of Supported Group Living/Supported Living will then notify the Executive Director. This step should be done within 24 hours. The Director of the program (SGL or SL) or designee will report the suspected abuse, neglect or exploitation within 24 hours of the initial report to the appropriate contacts, which may include:...Bureau of Developmental Disabilities Service Coordinator...The Director of the Program (SGL or SL) will assign an investigative team. A full investigation will be conducted by investigators who have received training from Labor Relations Association and ResCare's internal procedures or investigations...One of the investigators			

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W 0157 Bldg. 00	<p>will complete a detailed investigative case summary based on witness statements and other evidence collected...An investigative peer review committee chosen by the Executive Director will meet to discuss the outcome of the investigation and to ensure that a thorough investigation has been completed. Members of the committee must include at least one of the investigators, the Executive Director or designee, Director of Supported Living or SGL, and a Human Resources representative."</p> <p>This federal tag relates to complaint #IN00174697.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate</p>			

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	<p>corrective action must be taken.</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients (client A) to implement effective corrective action to protect client A from elopement behavior after a history of elopement had been identified.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports from 3/2015 through 6/2015 were reviewed on 6/17/15 at 2:58 PM and indicated the following:</p> <p>A BDDS report dated 5/27/15 indicated client A walked away from staff while shopping. Staff called the police and client A was found 2.5 miles away and returned to the group home. The report indicated client A has "excellent pedestrian safety skills and can keep himself safe." The report indicated client A's supervision level was increased to within eyesight while shopping.</p> <p>An investigation dated 5/29/15 into client A's elopement attached to the report indicated client A had left the store after being told the group home funds could not be used to purchase an individual soda for client A. Client A did not "look that upset and they continued to shop."</p>	W 0157	<p>W157: If the alleged violation is verified, appropriate corrective action must be taken. All staff will be retrained on Client A's BSP: specifically on his being within eyesight while in the community and in the home to protect him from going AWOL. The QIDP will be trained in completing a thorough investigation of any/all AWOLs that occur in the home which will include corrective action. The QIDP will review all behavior data on a monthly basis and make recommendations for changes based on the data. All internal incident reports will be reviewed by the Clinical Supervisor weekly to assure that those needing an investigation have had one completed. Clinical Supervisor, Program Manager and Executive Director will review all investigations as they are completed to assure that they are thorough and contain corrective action to prevent future occurrence.</p>	07/23/2015	

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	<p>Client A was following staff down the aisles, "When she turned around he was not in the aisle or by the cart." Police were called after a search of the store for client A and he was found by the police near an apartment complex. Client A indicated he "wanted a pop while at [store] and staff would not buy it. He said that staff always buys [client H] what he wants when they go out. He was upset so he left the store. He said that the police found him by some apartments and took him home." Staff #1 and #10 indicated "they do not purchase anything for an individual's use on [group home funds]." Staff #10 indicated they had purchased coffee and a bread as requested by client H as "it could be used by all the gentlemen in the home." Corrective action indicated elopement was added to client A's behavior plan and "staff will have [client A] within eyesight when in the community."</p> <p>Client A's record was reviewed on 6/17/15 at 4:25 PM. Client A's ISP (Individual Support Plan (ISP) dated 1/21/15 included a social history which indicated client A had graduated from high school with a diploma and had lived in an apartment alone in 2002 prior to unintentionally burning himself while smoking. Client A had a history of substance abuse and schizophrenia with</p>			

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	<p>noncompliance to take medications. Client A lived with family after being discharged from a mental health facility for noncompliance and moved into the group home on 2/22/12. The record indicated client A had a diagnosis of seizure disorder. "The IDT (interdisciplinary team) recommends that he have supervision while participating in community activities...[client A] has a history of non-compliance, over indulgence in caffeine, seeking revenge, and symptoms associated with schizophrenia (i.e., religious preoccupations, inappropriate sexual comments, in public naked, giving away possessions, etc.)." There was no evidence in the record client A had exhibited the identified history of symptoms of schizophrenia while living in the group home. The ISP indicated client A was "aware of possible dangers" (not specified).</p> <p>A Modification of Rights dated 1/21/15 indicated client A's freedom of movement was restricted to "areas of his home and the surrounding area supervised by staff. [Client A] will be supervised during activities within the community. When living with his [relative], [client A] left his home to get a pop at the gas station and returned with no problems."</p>			

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	<p>A Behavior Support Plan (BSP) dated 1/21/15 indicated target objectives of non-compliance, physical aggression, and leaving home without notification.</p> <p>"According to reports, [client A] left previous placements and family homes without notification when he wanted a pop. He has in the past walked to a local gas station and returned unharmed." The gas station named in previous incidents was located within 2 blocks of client A's group home. Interventions indicated "Be aware of [client A's] location every 5 minutes, and call the police if [client A] refuses to come home...." An addendum dated 6/1/15 indicated a target objective of "elopement (AWOL) (away without leave). [Client A] has demonstrated the ability to leave his home or staff in the community without notifying his residential staff. [Client A] has left staff supervision in the community while shopping and staff had to notify police, this action caused putting his safety at risk in the community." Interventions indicated "Residential staff should ensure they are walking behind [client A] in the community to ensure [client A] is present in the community."</p> <p>Additional BDDS reports and investigations of client A's elopement were reviewed on 6/23/15 at 11:50 AM.</p>			

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	<p>A BDDS report dated 8/29/14 indicated client A left the group home "without telling staff and was going to walk to a nearby gas station. Staff immediately followed [client A] down the street and convinced him to return to the home. He was not out of eyesight of the staff. He has a BSP for leaving the home and it was being followed. The QIDP (Qualified Intellectual Disabilities Professional) will review his BSP to see if there is need for any revision." The investigation dated 8/29/14-9/1/14 indicated client A did not want to wait for staff to go with him to the gas station, and staff immediately followed and remained with him the entire time he was out of the home. Findings indicated "15 minute checks were implemented in an attempt to keep [client A] safe."</p> <p>A BDDS report dated 9/20/14 indicated client A left the group home "unsupervised to get a pop at a gas station 2 blocks away. [Client A] was sitting on the front porch of the home: staff were completing their 15 minutes security checks on him. When staff went to do a check, he was not on the porch or in the home. Staff immediately went in the direction of the gas station and found [client A] walking back from the gas station with a pop." Corrective action</p>			

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	<p>indicated client A "will now be line of sight at the home and will have supervision if he wants to sit on the porch. It should be noted that [client A] has pedestrian safety skills and is aware of his environment and dangers in the community. [Client A] has walked to the gas station on numerous occasions. It is approximately 2 blocks away and there is a sidewalk all the way to the gas station." The investigation dated 9/25/14 indicated client A's plan had been changed to include 5 minute security checks and to keep client A within eyesight whenever outside his home." Client A "will have his own pop in the home."</p> <p>A BDDS report dated 12/4/14 indicated client A's roommate used an outlet he considered to be his and client A "became verbally aggressive and when staff attempted to redirect him, he pushed and swung at staff. When staff was unable to calm [client A] down, the police were called." Police arrived and talked to client A and left when they thought client A was calm. Client A then left the home and staff followed him. "After approximately 10 minutes, staff in the home called police for assistance. The police met up with [client A] and [staff #12] approximately one block from the home. [Client A] was escorted back to his home by the police." Corrective</p>			

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	<p>action indicated client A's IDT would meet and his plan was followed during the incident. The investigation dated 12/10/14 indicated client A "was upset about the use of an electrical plug located in his shared bedroom." Findings indicated staff would be trained on the importance of "appropriate word choice, voice tone, handling of power struggles, and interactions with clients." The IDT met and added physical aggression to client A's BSP, and client A was moved to a different bedroom.</p> <p>A BDDS report dated 1/25/15 indicated client A walked out of the group home with his hat and coat on and continued walking "despite staff requesting that he come back into the home. When it was apparent that [client A] was going to continue walking away, a staff member immediately followed him. He was within eyesight of the staff at all times. When he continued to walk and refused to come back to the home, the police were called to assist. The police returned [client A] and the staff to the home. Corrective action indicated the police "spoke with [client A] about leaving the home...AWOL is addressed in his BSP and the plan was being followed." There was no evidence of an investigation into the incident or of other corrective action.</p>			

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	<p>Client A's Comprehensive Functional Assessment (CFA) dated 6/9/14 indicated client A was independent in crossing the street by self, "obeys traffic signals and 'walk/don't walk' signs, looks both ways and waits as necessary before crossing the street...."</p> <p>The Program Manager of Supported Group Living (PMSGL) was interviewed on 6/22/15 at 3:10 PM and indicated client A had not eloped since January, 2015 until the incident on 5/27/15. She stated client A's plan was "further defined" after the incident on 5/27/15 where he left the grocery store and his plan had previously included leaving his home.</p> <p>The PMSGL was interviewed on 6/23/15 at 12:40 PM and indicated the incident of client A leaving the store placed him at risk, and stated, "But he was headed home. He has good pedestrian safety skills. At home he walked independently in the community, but mom is fearful he will have a seizure." The PMSGL indicated client A's elopement on 5/27/15 did not meet his supervision needs. She indicated she was unaware client A's plan had included the intervention for staff to keep him within eyesight at all times in the community at the time of his elopement on 5/27/15. She indicated she</p>			

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W 0249 Bldg. 00	<p>was unable to find evidence of an investigation or of corrective action into the incident of client A's elopement on 1/25/15.</p> <p>This federal tag relates to complaint #IN00174697.</p> <p>9-3-2(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients (client A) and and 1 additional client (client H) to implement clients A and H's plans for supervision.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of</p>	W 0249	W249: As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual	07/23/2015

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	<p>Developmental Disabilities Services) reports from 3/2015 through 6/2015 were reviewed on 6/17/15 at 2:58 PM and indicated the following:</p> <p>1. A BDDS report dated 5/27/15 indicated client A walked away from staff while shopping. Staff called the police and client A was found 2.5 miles away and returned to the group home. The report indicated client A has "excellent pedestrian safety skills and can keep himself safe." The report indicated client A's supervision level was increased to within eyesight while shopping.</p> <p>An investigation dated 5/29/15 into client A's elopement attached to the report indicated client A had left the store after being told the group home funds could not be used to purchase an individual soda for client A. Client A did not "look that upset and they continued to shop." Client A was following staff down the aisles, "When she turned around he was not in the aisle or by the cart." Police were called after a search of the store for client A and he was found by the police near an apartment complex. Client A indicated he "wanted a pop while at [store] and staff would not buy it. He said that staff always buys [client H] what he wants when they go out. He was upset so he left the store. He said that the police</p>		<p>program plan. All staff will be retrained on Client A's BSP: specifically on his being within eyesight while in the community and in the home to protect him from going AWOL. The QIDP will review all behavior data on a monthly basis and make recommendations for changes based on the data. Client H is no longer a consumer within our services. The QIDP will do twice weekly habilitation observations that will include observing and documenting active treatment within the home. The Clinical Supervisor will complete habilitation observations on a weekly basis for 30 days and reduce to 2 times per month to assure that clients are receiving continuous active treatment programs.</p>	

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	<p>found him by some apartments and took him home." Staff #1 and #10 indicated "they do not purchase anything for an individual's use on [group home funds]." Staff #10 indicated they had purchased coffee and a bread as requested by client H as "it could be used by all the gentlemen in the home." Corrective action indicated elopement was added to client A's behavior plan and "staff will have [client A] within eyesight when in the community."</p> <p>Client A's record was reviewed on 6/17/15 at 4:25 PM. Client A's ISP (Individual Support Plan (ISP) dated 1/21/15 included a social history which indicated client A had graduated from high school with a diploma and had lived in an apartment alone in 2002 prior to unintentionally burning himself while smoking. Client A had a history of substance abuse and schizophrenia with noncompliance to take medications. Client A lived with family after being discharged from a mental health facility for noncompliance and moved into the group home on 2/22/12. The record indicated client A had a diagnosis of seizure disorder. "The IDT (interdisciplinary team) recommends that he have supervision while participating in community activities...[client A] has a history of non-compliance, over</p>			
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	<p>indulgence in caffeine, seeking revenge, and symptoms associated with schizophrenia (i.e., religious preoccupations, inappropriate sexual comments, in public naked, giving away possessions, etc.)." There was no evidence in the record client A had exhibited the identified history of symptoms of schizophrenia while living in the group home. The ISP indicated client A was "aware of possible dangers" (not specified).</p> <p>A Modification of Rights dated 1/21/15 indicated client A's freedom of movement was restricted to "areas of his home and the surrounding area supervised by staff. [Client A] will be supervised during activities within the community. When living with his [relative], [client A] left his home to get a pop at the gas station and returned with no problems."</p> <p>A Behavior Support Plan (BSP) dated 1/21/15 indicated target objectives of non-compliance, physical aggression, and leaving home without notification. "According to reports, [client A] left previous placements and family homes without notification when he wanted a pop. He has in the past walked to a local gas station and returned unharmed." The gas station named in previous incidents</p>			

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	<p>was located within 2 blocks of client A's group home. Interventions indicated "Be aware of [client A's] location every 5 minutes, and call the police if [client A] refuses to come home..." An addendum dated 6/1/15 indicated a target objective of "elopement (AWOL) (away without leave). [Client A has demonstrated the ability to leave his home or staff in the community without notifying his residential staff. [Client A] has left staff supervision in the community while shopping and staff had to notify police, this action caused putting his safety at risk in the community." Interventions indicated "Residential staff should ensure they are walking behind [client A] in the community to ensure [client A] is present in the community."</p> <p>Additional BDDS reports and investigations of client A's elopement were reviewed on 6/23/15 at 11:50 AM.</p> <p>A BDDS report dated 8/29/14 indicated client A left the group home "without telling staff and was going to walk to a nearby gas station. Staff immediately followed [client A] down the street and convinced him to return to the home. He was not out of eyesight of the staff. He has a BSP for leaving the home and it was being followed. The QIDP (Qualified Intellectual Disabilities</p>			

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	<p>Professional) will review his BSP to see if there is need for any revision." The investigation dated 8/29/14-9/1/14 indicated client A did not want to wait for staff to go with him to the gas station, and staff immediately followed and remained with him the entire time he was out of the home. Findings indicated "15 minute checks were implemented in an attempt to keep [client A] safe."</p> <p>A BDDS report dated 9/20/14 indicated client A left the group home "unsupervised to get a pop at a gas station 2 blocks away. [Client A] was sitting on the front porch of the home: staff were completing their 15 minutes security checks on him. When staff went to do a check, he was not on the porch or in the home. Staff immediately went in the direction of the gas station and found [client A] walking back from the gas station with a pop." Corrective action indicated client A "will now be line of sight at the home and will have supervision if he wants to sit on the porch. It should be noted that [client A] has pedestrian safety skills and is aware of his environment and dangers in the community. [Client A] has walked to the gas station on numerous occasions. It is approximately 2 blocks away and there is a sidewalk all the way to the gas station." The investigation dated 9/25/14 indicated</p>			

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	<p>client A's plan had been changed to include 5 minute security checks and to keep client A within eyesight whenever outside his home." Client A "will have his own pop in the home."</p> <p>A BDDS report dated 12/4/14 indicated client A's roommate used an outlet he considered to be his and client A "became verbally aggressive and when staff attempted to redirect him, he pushed and swung at staff. When staff was unable to calm [client A] down, the police were called." Police arrived and talked to client A and left when they thought client A was calm. Client A then left the home and staff followed him. "After approximately 10 minutes, staff in the home called police for assistance. The police met up with [client A] and [staff #12] approximately one block from the home. [Client A] was escorted back to his home by the police." Corrective action indicated client A's IDT would meet and his plan was followed during the incident. The investigation dated 12/10/14 indicated client A "was upset about the use of an electrical plug located in his shared bedroom." Findings indicated staff would be trained on the importance of "appropriate word choice, voice tone, handling of power struggles, and interactions with clients." The IDT met and added physical aggression to</p>			

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	<p>client A's BSP, and client A was moved to a different bedroom.</p> <p>A BDDS report dated 1/25/15 indicated client A walked out of the group home with his hat and coat on and continued walking "despite staff requesting that he come back into the home. When it was apparent that [client A] was going to continue walking away, a staff member immediately followed him. He was within eyesight of the staff at all times. When he continued to walk and refused to come back to the home, the police were called to assist. The police returned [client A] and the staff to the home. Corrective action indicated the police "spoke with [client A] about leaving the home...AWOL is addressed in his BSP and the plan was being followed." There was no evidence of an investigation into the incident or of other corrective action.</p> <p>Client A's Comprehensive Functional Assessment (CFA) dated 6/9/14 indicated client A was independent in crossing the street by self, "obeys traffic signals and 'walk/don't walk' signs, looks both ways and waits as necessary before crossing the street..."</p> <p>The Program Manager of Supported Group Living (PMSGL) was interviewed on 6/22/15 at 3:10 PM and indicated</p>			

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	<p>client A had not eloped since January, 2015 until the incident on 5/27/15. She stated client A's plan was "further defined" after the incident on 5/27/15 where he left the grocery store and his plan had previously included leaving his home.</p> <p>The PMSGL was interviewed on 6/23/15 at 12:40 PM and indicated the incident of client A leaving the store placed him at risk, and stated, "But he was headed home. He has good pedestrian safety skills. At home he walked independently in the community, but mom is fearful he will have a seizure." The PMSGL indicated client A's elopement on 5/27/15 did not meet his supervision needs. She indicated she was unaware client A's plan had included the intervention for staff to keep him within eyesight at all times in the community at the time of his elopement on 5/27/15. She indicated she was unable to find evidence of an investigation or of corrective action into the incident of client A's elopement on 1/25/15.</p> <p>2. A BDDS report dated 4/3/15 indicated client H left the group home "around 10:00 PM by climbing out his bedroom window and walked approximately 2.5 miles to his mother's apartment. [Client H] was upset with a peer and staff</p>			

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	<p>member." Corrective action indicated client H's mother brought him back to the group home. "He has excellent pedestrian safety skills and it is in his plan that he is able to be away from the group home unsupervised, however it is time limited and staff are to be informed prior to his leaving. His BSP (Behavior Support Plan) will be reviewed and revised as needed." A follow up report dated 4/9/15 indicated client H's plan included "up to 15 minutes of unsupervised time away from home." Client H indicated client A went to client H's room and "was 'staring' at him. He yelled at [client A] to get out of his room and to quit staring. [Client A] stood in his doorway a little bit. [Client H] then said he went to [client A's] room and 'trashed' it. When asked what he did, he said he kicked [client A's] chair, turned up his radio, and pushed more stuff off his dresser. He said that [staff #6] told him that if he touched anyone she would call the police and his probation officer. This 'p-----' him off because he didn't want anyone calling his probation officer and she [staff #6] shouldn't have said that." After client H arrived at his mother's house, his mother attempted to contact a mental health facility for client H, "but they said he couldn't come there," and client H's mother returned him to the group home "about 11:30 pm." The conclusion</p>			

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	<p>indicated client H "will be on 5 minute security checks for the next 30 days, then he will be on 15 minute security checks...."</p> <p>Client H's record was reviewed on 6/22/15 at 3:35 PM. A BSP dated 1/2/15 indicated target objectives of physical aggression, self injury, trash picking (going through trash bins), hoarding property destruction and elopement. The BSP indicated client H had collected 2 nonworking computers, taken them apart and put the parts back together to form a working computer. A Modification of Individual Rights dated 2/3/15 indicated client H "is able to go on the porch, in the yard, down the street on his bike, or down the street to the nearest gas station [name of gas station] with a 15 minute cap. [Client H] will be supervised during activities within the community. [Client H] is aware of possible dangers and does possess good pedestrian safety." A CFA dated 2/3/15 indicated client H was independent in pedestrian safety skills.</p> <p>The PMSGL was interviewed on 6/23/15 at 12:42 PM and indicated client H's supervision needs weren't met when he eloped from the group home.</p> <p>This federal tag relates to complaint #IN00174697.</p>			

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W 0322 Bldg. 00	<p>9-3-4(a)</p> <p>483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based upon record review and interview, the facility failed for 1 of 3 sampled clients (client A) to ensure client A's annual physical was completed.</p> <p>Findings include:</p> <p>Client A's record was reviewed on 6/17/15 at 4:25 PM. An annual physical examination form dated 4/9/14 was the most recent physical examination in the record.</p> <p>Program Manager of Supported Group Living (PMSGGL) was interviewed on 6/22/15 at 3:25 PM and indicated client A's physical examination was scheduled, but was overdue.</p> <p>9-3-6(a)</p>	W 0322	<p>W322 The facility must provide or obtain preventive and general medical care. The nurse will complete a checklist that includes dates of all physicals, vision exams, etc that will be forwarded to the Nurse Manager on a monthly basis to assure that all exams are completed in a timely manner. The medical coach in each home will be retrained on completing their Monthly Medical Tracking Book and keeping it up to date to assure that all medical appointments that need to be scheduled have been scheduled. The QIDP will review medical charts on a monthly basis to assure that all appointments have been scheduled and/or completed. The Nurse manager and Clinical Supervisor will audit the medical charts on a quarterly basis to assure that medical appointments have been scheduled and/or completed in a</p>	07/23/2015

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W 0323  Bldg. 00	<p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based upon record review and interview, the facility failed for 1 of 3 sampled clients (client C) to ensure client C's vision was evaluated as recommended.</p> <p>Findings include:</p> <p>Client C's record was reviewed on 6/23/15 at 12:05 PM. A vision examination dated 4/4/12 indicated client C was to have his vision re-examined in 4/14. There was no evidence of a more recent evaluation of client C's vision.</p> <p>The Manager of Supported Group Living was interviewed on 6/23/15 at 12:40 PM and indicated clients C's vision examination was overdue.</p> <p>9-3-6(a)</p>	W 0323	<p>timely manner.</p> <p>W323: The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. The nurse will complete a checklist that includes dates of all physicals, vision exams, etc that will be forwarded to their Nurse Manager on a monthly basis to assure that all exams are completed in a timely manner. The medical coach in each home will be retrained on completing their Monthly Medical Tracking Book and keeping it up to date to assure that all medical appointments that need to be scheduled have been scheduled. The QIDP will review medical charts on a monthly basis to assure that all appointments have been scheduled and/or completed. The Nurse manager and Clinical Supervisor will audit the medical charts on a quarterly basis to assure that medical appointments have been scheduled and/or completed in a timely manner</p>	07/23/2015	