STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G481	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE DESIGNS INC	532 RIDGEVIEW COLUMBUS, IN 47203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	This visit was for the post certification revisit to a full recertification and state licensure survey completed on 9/12/14 which resulted in an Immediate Jeopardy. Dates of Survey: October 28, 29, 30, 31 and November 3, 2014. Facility number: 000995 Provider number: 15G481 AIM number: 100235470 Surveyor: Susan Reichert, QIDP The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/13/14 by Ruth Shackelford, QIDP.	W000000		
W000102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on record review, observation and	W000102	Incidents referenced for client #1 that occurred on 10/4/14 and	12/03/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	interview, the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to provide oversight and direction to ensure implementation of their policy and procedures to prevent neglect by failing to develop and implement effective corrective action to address the physically and verbally aggressive and sexually inappropriate behavior of client #1 and the physically aggressive behavior of client #2. The governing body failed to ensure oversight and direction to ensure timely reporting of 2 of 2 allegations of abuse involving client #1, and 5 of 7 incidents of verbally and physically aggressive behavior and sexually inappropriate behavior involving client #1. The governing body failed to provide oversight and direction to report 1 of 2 incidents of physically aggressive behavior involving clients #1 and #2. The governing body failed provide oversight and direction to protect clients #1, #2 and #3 from further potential abuse during an investigation of alleged abuse involving client #1. The governing body failed to provide oversight and direction to complete a thorough investigation into 3 of 7 incidents of physically aggressive behavior, and 1 of 2 allegations of abuse involving client #1, and failed to complete an investigation with corrective action into 1 of 2 incidents of physically		10/27/14 were not originally reported to BDDS because they do not meet the defined reporting criteria per DDRS Incident Reporting Policies; however, in order to correct the deficient practice, BDDS reports will be completed for those incidents. Likewise, incidents of physical aggression, when those incidents did not involve aggression towards another customer, were not investigated, as these are not considered abuse towards another individual;however, in order to correct the deficient practice, those incidents will be further investigated . There was a short period of time in October when interfering behaviors increased in frequency,resulting in some late reporting. Behaviors have since decreased. All incidents were debriefed in team meetings, and ways to prevent or respond in a better way were discussed. All staff have been retrained on the requirement to report all allegations immediately. Staff taking notes will be re-trained to be diligent in including detailed records of all team discussions in order to maintain comprehensive documentation.Additionally, an investigation will be completed for the incident that occurred on 10/26/14, in reference to client #1 indicating that staff choked him. To prevent the deficient practice from recurrence, staff have access to a scanner/e-mail in the	

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	aggressive by client #2 involving client #1. Findings include: 1. The governing body failed to meet the Condition of Participation: Client Protections by failing to provide oversight and direction to implement policy and procedures to develop and implement effective corrective action to address the physically and verbally aggressive and sexually inappropriate behavior of client #1 and the physically aggressive behavior of client #2. The governing body failed to provide oversight and direction to implement policy and procedure to protect 1 of 2 sampled clients (client #1) by failing to timely report 2 of 2 allegations of abuse involving client #1, and 5 of 7 incidents of verbally and physically aggressive behavior and sexually inappropriate behavior involving client #1. The governing body failed to provide oversight and direction to report 1 of 2 incidents of physically aggressive behavior involving clients #1 and #2. The governing body failed to provide oversight and direction to protect clients #1, #2 and #3 from further potential abuse during an investigation of alleged abuse involving client #1. The governing body failed to provide oversight and		home, and have been instructed to scan & e-mail all Unusual Incident Reports to the ND/Q, Director of Residential Services (DORS) and Director of Support Services (DOSS) to ensure information is shared timely, and necessary action is taken right away. A reminder has also been posted on the AccelTrax system, the electronic system that all LifeDesigns staff utilize to report time and progress notes at the end of each shift. All supervisory staff will be retrained on all policies/ procedures related to incident reporting and investigations, including the importance of timely reporting, ensuring staff are suspended when abuse/ neglect has been alleged, and thorough documentation of all resulting corrective action. The ND/Q will be in the home no less than twice weekly, in addition to weekly team meetings, in order to provide ongoing monitoring. Additionally, the DORS will be on-site no less than monthly, and the CEO will complete a quarterly on-site visit to review the overall setting and documentation. Additional ongoing monitoring will be completed by the Services Leadership team, who meet at least twice a month to review all BDDS reports and investigations. The Behavior Support Plans were revised for all young men living in the home only 2 months ago, and have undergone a number of	

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	direction to complete a thorough investigation into 3 of 7 incidents of physically aggressive behavior, and 1 of 2 allegations of abuse involving client #1, and neglected to complete an investigation with corrective action into 1 of 2 incidents of physically aggressive by client #2 involving client #1. Please see W122. 2. The governing body failed to provide oversight and direction to ensure implementation of their policy and procedures to prevent neglect by failing to develop and implement effective corrective action to address the physically, verbally aggressive and sexually inappropriate behavior of client #1 and the physically aggressive behavior of client #2. The governing body failed to ensure oversight and direction to ensure timely reporting of 2 of 2 allegations of abuse involving client #1, and 5 of 7 incidents of verbally and physically aggressive behavior and sexually inappropriate behavior involving client #1. The governing body failed to provide oversight and direction to report 1 of 2 incidents of physically aggressive behavior involving clients #1 and #2. The governing body failed provide oversight and direction to protect clients #1, #2 and #3 from further potential abuse during an investigation of alleged abuse involving		revisions/enhancements, as a result of ongoing feedback from staff, based on their observations and experiences. At the same time the new BSPs were implemented,new activity schedules were introduces, involving the men in a wider variety of activities, and placing a higher level of expectations on them in regards to more community involvement, as well as expectations to increase independence at home. While it is true that interfering behaviors have not been completely eliminated, there has been a significant decrease in the frequency and severity of behaviors, and an increase in staff's ability and competence to respond in a consistent and appropriate manner. Staff will continue to meet at least twice per month, and will review all behavioral incidents and determine if strategies are effective, or if revisions to the BSPs are necessary. The Behavior Specialist continues to observe customers living in the home at least weekly,and is available by phone for consultation. She also trains each new staff on the BSPs to ensure competency. Ongoing monitoring will be accomplished through the Residential Services Monthly Report, which provides a compilation of BDDS report information, as well as behavior data, and is disseminated to the	

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	client #1. The governing body failed to provide oversight and direction to complete a thorough investigation into 3 of 7 incidents of physically aggressive behavior, and 1 of 2 allegations of abuse involving client #1, and failed to complete an investigation with corrective action into 1 of 2 incidents of physically aggressive by client #2 involving client #1. Please see W104. This condition was cited on September 12, 2014. The facility failed to implement a systemic plan of correction to prevent reoccurrence. 9-3-1(a)		IST for review.	

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W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based upon observation, interview and record review, the governing body failed to provide oversight and direction to ensure implementation of their policy and procedures to prevent neglect by failing to develop and implement effective corrective action to address the physically and verbally aggressive and sexually inappropriate behavior of client #1 and the physically aggressive behavior of client #2. The governing body failed to ensure oversight and direction to ensure timely reporting of 2 of 2 allegations of abuse involving client #1, and 5 of 7 incidents of verbally and physically aggressive behavior and sexually inappropriate behavior involving client #1. The governing body failed to provide oversight and direction to report 1 of 2 incidents of physically aggressive behavior involving clients #1 and #2. The governing body failed provide oversight and direction to protect clients #1, #2 and	W000104	Incidents referenced for client #1 that occurred on 10/4/14and 10/27/14 were not originally reported to BDDS because they do not meet thedefined reporting criteria per DDRS Incident Reporting Policies; however, inorder to correct the deficient practice, BDDS reports will be completed forthose incidents. Likewise, incidents of physical aggression, when thoseincidents did not involve aggression towards another customer, were notinvestigated, as these are not considered abuse towards another individual;however, in order to correct the deficient practice, those incidents will befurther investigated . There was a shortperiod of time in October when interfering behaviors increased in frequency,resulting in some late reporting. Behaviors have since decreased. All incidentswere debriefed in team meetings, and ways to prevent or respond in a better waywere discussed. All staff have been retrained on the	12/03/2014

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	#3 from further potential abuse during an investigation of alleged abuse involving client #1. The governing body failed to provide oversight and direction to complete a thorough investigation into 3 of 7 incidents of physically aggressive behavior, and 1 of 2 allegations of abuse involving client #1, and failed to complete an investigation with corrective action into 1 of 2 incidents of physically aggressive by client #2 involving client #1. Findings include: 1. The governing body failed to implement its policy and procedures to prevent neglect by failing to implement policy and procedures to develop and implement effective corrective action to address the physically and verbally aggressive and sexually inappropriate behavior of client #1 and the physically aggressive behavior of client #2. The governing body failed to implement policy and procedure to protect 1 of 2 sampled clients (client #1) by failing to timely report 2 of 2 allegations of abuse involving client #1, and 5 of 7 incidents of verbally and physically aggressive behavior and sexually inappropriate behavior involving client #1. The governing body failed to report 1 of 2 incidents of physically aggressive		requirement to report allallegations immediately. Staff takingnotes will be re-trained to be diligent in including detailed records of allteam discussions in order to maintain comprehensive documentation.Additionally, an investigation will be completed for the incident that occurredon 10/26/14, in reference to client #1 indicating that staff choked him. Toprevent the deficient practice from recurrence, staff have access to a scanner/e-mail in the home, and have been instructed to scan & e-mail all UnusualIncident Reports to the ND/Q, Director of Residential Services (DORS) andDirector of Support Services (DOSS) to ensure information is shared timely, andnecessary action is taken right away. A reminder has also been posted on theAccelTrax system, the electronic system that all LifeDesigns staff utilize toreport time and progress notes at the end of each shift. All supervisory staffwill be retrained on all policies/ procedures related to incident reporting andinvestigations, including the importance of timely reporting, ensuring staffare suspended when abuse/ neglect has been alleged, and thorough documentationof all resulting corrective action. The ND/Q will be in the home no less thantwice weekly, in addition to weekly team meetings, in order to provide	

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	behavior involving clients #1 and #2. The governing body failed to protect clients #1, #2 and #3 from further potential abuse during an investigation of alleged abuse involving client #1. The governing body failed to complete a thorough investigation into 3 of 7 incidents of physically aggressive behavior, and 1 of 2 allegations of abuse involving client #1, and failed to complete an investigation with corrective action into 1 of 2 incidents of physically aggressive by client #2 involving client #1. Please see W149. 2. The governing body failed to provide oversight and direction to timely report 2 of 2 allegations of abuse involving client #1, and 5 of 7 incidents of verbally and physically aggressive behavior and sexually inappropriate behavior involving client #1. The governing body failed to provide oversight and direction to report 1 of 2 incidents of physically aggressive behavior involving clients #1 and #2 in accordance with state law. Please see W153. 3. The governing body failed to complete a thorough investigation into 3 of 7 incidents of physically aggressive behavior, and 1 of 2 allegations of abuse involving client #1, and failed to provide oversight and direction to complete an		ongoing monitoring.Additionally, the DORS will be on-site no less than monthly, and the CEO willcomplete a quarterly on-site visit to review the overall setting anddocumentation. Additional ongoing monitoring will be completed by the ServicesLeadership team, who meet at least twice a month to review all BDDS reports andinvestigations. W157 The BehaviorSupport Plans were revised for all young men living in the home only 2 monthsago, and have undergone a number of revisions/ enhancements, as a result ofongoing feedback from staff, based on their observations and experiences. Atthe same time the new BSPs were implemented, new activity schedules wereintroduces, involving the men in a wider variety of activities, and placing ahigher level of expectations on them in regards to more community involvement,as well as expectations to increase independence at home. While it is true thatinterfering behaviors have not been completely eliminated, there has been asignificant decrease in the frequency and severity of behaviors, and anincrease in staff's ability and competence to respond in a consistent andappropriate manner. Staff will continue to meet at least twice per month, andwill review all	

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	investigation with corrective action into 1 of 2 incidents of physically aggressive by client #2 involving client #1. Please see W154. 4. The governing body failed to failed to protect clients #1, #2 and #3 from further potential abuse during an investigation of alleged abuse involving client #1. Please see W155. 5. The governing body failed to develop and implement effective corrective action to address the physically and verbally aggressive and sexually inappropriate behavior of client #1 and the physically aggressive behavior of client #2. Please see W157. This deficiency was cited on September 12, 2014. The facility failed to implement a systemic plan of correction to prevent reoccurrence. 9-3-1(a)		behavioral incidents and determine if strategies are effective,or if revisions to the BSPs are necessary. The Behavior Specialist continues toobserve customers living in the home at least weekly, and is available by phonefor consultation. She also trains each new staff on the BSPs to ensurecompetency. Ongoing monitoring will be accomplished through the ResidentialServices Monthly Report, which provides a compilation of BDDS reportinformation, as well as behavior data, and is disseminated to the IST forreview.	

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W000122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview, the facility failed to meet the Condition of Participation: Client Protections by neglecting to implement policy and procedures to develop and implement effective corrective action to address the physically and verbally aggressive and sexually inappropriate behavior of client #1 and the physically aggressive behavior of client #2. The facility neglected to implement policy and procedure to protect 1 of 2 sampled clients (client #1) by failing to timely report 2 of 2 allegations of abuse involving client #1, and 2 of 3 incidents of verbally and physically aggressive behavior and sexually inappropriate behavior involving client #1. The facility neglected to report 1 of 2 incidents of physically aggressive behavior involving clients #1 and #2. The facility neglected to protect clients #1, #2 and #3 from further potential abuse during an investigation of alleged abuse involving client #1. The facility neglected failed to complete a thorough	W000122	Incidents referenced for client #1 that occurred on 10/4/14 and 10/27/14 were not originally reported to BDDS because they do not meet the defined reporting criteria per DDRS Incident Reporting Policies; however, in order to correct the deficient practice, BDDS reports will be completed for those incidents. Likewise, incidents of physical aggression, when those incidents did not involve aggression towards another customer, were not investigated, as these are not considered abuse towards another individual;however, in order to correct the deficient practice, those incidents will be further investigated . There was a short period of time in October when interfering behaviors increased in frequency,resulting in some late reporting. Behaviors have since decreased. All incidents were debriefed in team meetings, and ways to prevent or respond in a better way were discussed. All staff have been retrained on the requirement to report all allegations immediately. Staff taking notes	12/03/2014

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	investigation into 5 of 7 incidents of physically aggressive behavior, and 1 of 2 allegations of abuse involving client #1, and neglected to complete an investigation with corrective action into 1 of 2 incidents of physically aggressive by client #2 involving client #1. Findings include: 1. The facility failed to implement its policy and procedures to prevent neglect by failing to implement policy and procedures to develop and implement effective corrective action to address the physically, verbally aggressive and sexually inappropriate behavior of client #1 and the physically aggressive behavior of client #2. The facility failed to implement policy and procedure to protect 1 of 2 sampled clients (client #1) by failing to timely report 2 of 2 allegations of abuse involving client #1, and 2 of 3 incidents of verbally and physically aggressive behavior and sexually inappropriate behavior involving client #1. The facility failed to report 1 of 2 incidents of physically aggressive behavior involving clients #1 and #2. The facility failed to protect clients #1, #2 and #3 from further potential abuse during an investigation of alleged abuse involving client #1. The facility failed to complete a thorough investigation into 5		will be re-trained to be diligent in including detailed records of all team discussions in order to maintain comprehensive documentation.Additionally, an investigation will be completed for the incident that occurred on 10/26/14, in reference to client #1 indicating that staff choked him. To prevent the deficient practice from recurrence, staff have access to a scanner/e-mail in the home, and have been instructed to scan & e-mail all Unusual Incident Reports to the ND/Q, Director of Residential Services (DORS) and Director of Support Services (DOSS) to ensure information is shared timely, and necessary action is taken right away. A reminder has also been posted on the AccelTrax system, the electronic system that all LifeDesigns staff utilize to report time and progress notes at the end of each shift. All supervisory staff will be retrained on all policies/ procedures related to incident reporting and investigations, including the importance of timely reporting, ensuring staff are suspended when abuse/ neglect has been alleged, and thorough documentation of all resulting corrective action. The ND/Q will be in the home no less than twice weekly, in addition to weekly team meetings, in order to provide ongoing monitoring. Additionally, the DORS will be on-site no less than monthly, and the CEO will	

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	of 7 incidents of physically aggressive behavior, and 1 of 2 allegations of abuse involving client #1, and failed to complete an investigation with corrective action into 1 of 2 incidents of physically aggressive by client #2 involving client #1. Please see W149. 2. The facility failed to timely report 5 of 7 allegations of abuse involving client #1, and 2 of 3 incidents of verbally and physically aggressive behavior and sexually inappropriate behavior involving client #1. The facility failed to report 1 of 2 incidents of physically aggressive behavior involving clients #1 and #2. Please see W153. 3. The facility failed to complete a thorough investigation into 3 of 7 incidents of physically aggressive behavior, and 1 of 2 allegations of abuse involving client #1, and failed to complete an investigation with corrective action into 1 of 2 incidents of physically aggressive by client #2 involving client #1. Please see W154. 4. The facility failed to failed to protect clients #1, #2 and #3 from further potential abuse during an investigation of alleged abuse involving client #1. Please see W155.		complete a quarterly on-site visit to review the overall setting and documentation. Additional ongoing monitoring will be completed by the Services Leadership team, who meet at least twice a month to review all BDDS reports and investigations.The Behavior Support Plans were revised for all young men living in the home only 2 months ago, and have undergone a number of revisions/ enhancements, as a result of ongoing feedback from staff, based on their observations and experiences. At the same time the new BSPs were implemented, new activity schedules were introduces, involving the men in a wider variety of activities, and placing a higher level of expectations on them in regards to more community involvement,as well as expectations to increase independence at home. While it is true that interfering behaviors have not been completely eliminated, there has been a significant decrease in the frequency and severity of behaviors, and an increase in staff's ability and competence to respond in a consistent and appropriate manner. Staff will continue to meet at least twice per month, and will review all behavioral incidents and determine if strategies are effective,or if revisions to the BSPs are necessary. The	

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	5. The facility failed to develop and implement effective corrective action to address the physically and verbally aggressive and sexually inappropriate behavior of client #1 and the physically aggressive behavior of client #2. Please see W157. This condition was cited on September 12, 2014. The facility failed to implement a systemic plan of correction to prevent reoccurrence. 9-3-2(a)		Behavior Specialist continues to observe customers living in the home at least weekly, and is available by phone for consultation. She also trains each new staff on the BSPs to ensure competency. Ongoing monitoring will be accomplished through the Residential Services Monthly Report, which provides a compilation of BDDS report information, as well as behavior data, and is disseminated to the IST for review.	
W000149	483.420(d)(1)			

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NAME OF PROVIDER OR SUPPLIER LIFE DESIGNS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 532 RIDGEVIEW COLUMBUS, IN 47203	

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	STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based upon record review and interview, the facility failed to implement its policy and procedures to prevent neglect by failing to implement policy and procedures to develop and implement effective corrective action to address the physically and verbally aggressive and sexually inappropriate behavior of client #1 and the physically aggressive behavior of client #2. The facility failed to implement policy and procedure to protect 1 of 2 sampled clients (client #1) by failing to timely report 2 of 2 allegations of abuse involving client #1, and 2 of 3 incidents of verbally and physically aggressive behavior and sexually inappropriate behavior involving client #1. The facility failed to report 1 of 2 incidents of physically aggressive behavior involving clients #1 and #2. The facility failed to protect clients #1, #2 and #3 from further potential abuse during an investigation of alleged abuse involving client #1. The facility failed to complete a thorough investigation into 5 of 7 incidents of physically aggressive behavior, and 1 of 2 allegations of abuse involving client #1, and failed to complete an investigation with corrective action into 1 of 2 incidents of physically	W000149	Incidents referenced for client #1 that occurred on 10/4/14 and 10/27/14 were not originally reported to BDDS because they do not meet the defined reporting criteria per DDRS Incident Reporting Policies; however, in order to correct the deficient practice, BDDS reports will be completed for those incidents. Likewise, incidents of physical aggression, when those incidents did not involve aggression towards another customer, were not investigated, as these are not considered abuse towards another individual;however, in order to correct the deficient practice, those incidents will be further investigated. All incidents were debriefed in team meetings, and ways to prevent or respond in a better way were discussed. Staff taking notes will be re-trained to be diligent in including detailed records of all team discussions in order to maintain comprehensive documentation. Additionally, an investigation will be completed for the incident that occurred on 10/26/14, in reference to client #1 indicating that staff choked him. To prevent the deficient practice from recurrence, staff have access to a scanner/ e-mail in the home, and have been instructed to scan & e-mail all Unusual	12/03/2014

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	aggressive by client #2 involving client #1. Findings include: Unusual Incident Reports (UIRs) were reviewed on 10/28/14 at 6:30 PM and included the following reports: For client #1: An UIR dated 9/29/14 indicated client #1 got out of bed at 9:00 PM and stated that he "wanted to pick on [staff #4]." Client #1 "proceeded to make rude gestures and asked about Jubilee dessert (which had been the trigger of a previous behavior incident) and reached for his shorts." Client #1 was redirected from urinating on the floor, staff #3 redirected client #1 to his room and redirected client #1 to breathing exercises and implemented rubbing client's #1 back with finger tips and discussed calming techniques for client #1 to use. An UIR dated 10/4/14 at 1:00 PM indicated client #1 was brought back early from a visit with a relative to attend a Special Olympic bowling event. On the way to the event, client #1, "yelled wiener", calmed down, then went into the bowling alley to play video games. Once his money was gone, client #1 "flipped		Incident Reports to the ND/Q, Director of Residential Services (DORS) and Director of Support Services (DOSS) to ensure information is shared timely, and necessary action is taken right away. All supervisory staff will be retrained on all policies/procedures related to incident reporting and investigations, including the importance of timely reporting, ensuring staff are suspended when abuse/neglect has been alleged, and thorough documentation of all resulting corrective action. The ND/Q will be in the home no less than twice weekly, in addition to weekly team meetings, in order to provide ongoing monitoring.Additionally, the DORS will be on-site no less than monthly, and the CEO will complete a quarterly on-site visit to review the overall setting and documentation. Additional ongoing monitoring will be completed by the Services Leadership team, who meet at least twice a month to review all BDDS reports and investigations.	

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	off" (profane gesture) staff from another group home. The incident report indicated during the incident client #1 hit and grabbed client #2, and upon returning home, "walked around the house kicking the house and banging on windows. When [client #1] saw that staff wasn't reacting to him beating on the house windows, he went to the neighbors house," rang their doorbell and attempted "to beat on" the neighbor's windows, but was redirected by staff. Client #1 "ruminated" about the police being called (no indication police were called in the report) and whether the neighbors would call police. Client #1 remained on their porch for an hour until the TM (Team Manager) on call arrived and escorted client #1 off the neighbor's property. Client #1 then tried to go to another neighbor's house, but was redirected, and continued to make "rude remarks and obscene gestures throughout the entire evening." After client #1 returned to the group home, he opened his bedroom window, "several times" pulled down his pants and "flipped off" the neighbors. Client #1 "eventually calmed down," then went on a van ride with clients #2 and #3 and 2 overnight staff. The report indicated the incident did not require investigation. An UIR dated 10/5/14 (time not			

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	indicated) indicated while staff (unidentified) was preparing breakfast and staff #5 was preparing medications for administration, client #1 asked if staff #5 was going to "call the cops" or if neighbors would call the cops. Client #1 called the police from the group home office and when they arrived, client #1 "exposed his genitals" to police and tried to "grab" them as they left. The report indicated during the conversation between client #1 and police "that it was inappropriate to prank call police and next time it might not just be a talking to." Client #1 sat in the office with staff #5 and "ruminated on calling the police, going to Oktoberfest, getting neighbors to call the police." Client #1 "proceeded to try and exit residence stating that he was going to make them 'call the cops'." There was no indication client #1 left the group home during the incident. Client #2 went on an outing and client #3 went home while staff #5 stayed with client #1. There was no evidence the incident involving client #1 calling police, exposing his genitals or attempting to grab the police upon their exit from the home was reported to the BDDS office or investigated. There was no evidence of corrective action. An UIR signed on 10/23/14 completed by the TM indicated on 10/20/14 at 4:30			

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	PM indicated "Duration of behavior, 4 hours." Client #1 saw neighbor kids and made "kissing noises and taunts...DSP (Direct Support Professional) tried verbal redirection." Writer (TM) intervened and prompted [client #1] to take a walk. [Client #1] complied. [Client #1] returned to home and continued making inappropriate comments/verbally aggressive. TM and DSP attempted verbal redirection, active ignoring, and proactive measures using careplan, but [client #1] continued. TM physically prompted [client #1] to take a walk by placing his hand on [client #1's] back. [Client #1] walked w/ (with) TM, but became agitated when a dog barked at him. When TM and [client #1] returned, TM prompted [client #1] to call his [relatives]. [Client #1] made verbal threats re: dog and others. TM directed [client #1] to take another walk, but [client #1] refused. [Client #1] dropped in the middle of the street and refused to walk. TM stood nearby as [client #1] made threats at neighbors who passed, yelling "F___you," and "Can I kill you?" Client #1 also pulled his pants down while in the street. The TM "physically prompted [client #1] to roll to his side then stand and return to the house." Client #1 went to his room, then left his room, "and continued to be verbally aggressive, threatening staff/TM asking,			

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	"Can I kick you,"Can I spit on you," and "Can I bite you?" Client #1 was directed to use his emotions chart in his room, and [client #1] followed TM and [staff #2] prompted client #1 to walk in the back yard. [Client #1] complied. When overnight staff #4 arrived to work in the home at 8:00 PM, she waited for client #1 to return to his room. Client #1 returned to his room, and staff #2 "stopped him from reaching [staff #4] (whom he was targeting)." Client #1 "continued to make threats, asking 'Can I pick on [staff #4]?'" TM "physically prompted [client #1] to continue his walk using [physical hold/escort technique]. [Client #1] walked w/ TM though he attempted to bite, kick, and spit on TM. When [client #1] finished his walk he went to his bed @ (at) 8:30 PM and remained there for the rest of the evening." An UIR dated 10/26/14 from 8:25 PM-10:00 PM indicated "Duration of the behavior 1 hour, 54 minutes." Staff #3 left at 8:25 PM along with staff #1 as client #1 was lying down in his room "and all residents were quiet and in their bed (sic). On call [TM] had called staff back at 8:00 PM. Staff #1 talked to [TM] on phone then staff #1 informed me that TM told her that one of us had to stay until 10 PM (if there was an issue) even			

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	after [staff #1] made it clear that she couldn't ...and [staff #3's] car was being worked on so [staff #3] didn't have a way home. Staff #3 received a phone call from [TM] asking writer to come back because [staff #4] had called and asked [staff #5] to come in due to [client #1] coming out of his room and finding [staff #4] and (client #1) making the statement 'You choked me, I'm going to call the cops'. [Staff #5] claimed to have tried to reach [TM] by phone and pager but was unsuccessful. Staff did not successfully reach the on call [TM] after he called the house at 8:00 PM." Staff #3 arrived at the house at 8:34 PM, staff #4 stepped out of client #1's sight, and client #1 was directed into his room by staff #3. "Ten minutes later, [client #1] came out of room (sic), stating 'Can I pick on [staff #4]?'" [Client #1]...opened [client #2's] door and ran for [client #2's] bed. [Staff #3] used approved CPI escort to remove [client #1] from room and prevent [client #2] from coming to harm. [Client #1] returned to his room and was asleep by 10:05 PM." There was no evidence of an investigation or of corrective action. An UIR dated 10/27/14 indicated "Duration of behavior; 1 hour, 45 minutes." Client #1 asked staff if he could get a butter knife and hurt people with it. Client #1 made kissing noises at			

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	the neighbor's house and "ruminated" regarding calling the cops and having CPI used on him. Client #1 beat on the counters with a metal spoon and "threatened to hit some of the other individuals with it." Client #1 "mentioned to [staff #2] that he was acting like this because he had anxiety about the TM's being here because he didn't want to be CPI escorted anymore." When the TM came to the group home, client #1 "started asking the TM if he was going to do CPI on him." Client #1 went to one of the neighbor's houses and "attempted to ring the door bell and flip them off." Client #1 asked if the neighbors would call the police, and was redirected off the neighbor's property. While walking from the neighbor's property client #1 "decided to go on another neighbor's property and attempt to ring their doorbell and upset them." The group home nurse, NDQ (Network Director/QIDP (Qualified Intellectual Disabilities Professional), and staff #1 and #2 were able to redirect client #1 back to the group home and client #1 assisted staff #2 in making dinner. "When the TM came in with the other individuals, [client #1] started getting worked up again. He went into the living room where individual [client #3] was trying to watch a movie and started sticking that individual's exercise band in			

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	his mouth in an attempt to upset [client #3]. He was also mocking the [TM] a lot." Staff #2 redirected client #1 back to his room and talked to him about why he was getting himself worked up again after he had just calmed down. [Client #1] told [staff #1] that he still had anxiety about the [TM] and being CPI escorted....." The report indicated the incident was reported to BDDS and would be investigated. There was no evidence of corrective action in the report. An UIR dated 10/27/14 from 9:45 PM -11:30 PM indicated "Duration of behavior 1 hour and 45 minutes." Client #1 "got out of bed and asked where the overnight person was because he wanted to tease her." Staff #2 "went to help [client #1] calm down and go back to bed. [Client #1] insisted on staying up late and yelling inappropriate words trying to wake up the other consumers." Client #1 got his ventriloquist dummy and "started making inappropriate gestures and saying inappropriate things about the dummy." Client #1 called a relative twice and the QAD (Quality Assurance Director) and spoke about fishing before going back to bed. Staff #2 "rubbed [client #1's] arm and hand upon his request, and scratched his back until he was ready to go to sleep." There was			

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	no evidence of corrective action in the report. For client #2: An UIR dated 10/4/14 MR at 4:00 PM indicated client #2 tried to drink from a beer tap behind the bar at a bowling alley before staff could intervene. Client #2 attempted to drink from the tap and yelled "Just one beer" and left the bowling alley after Special Olympic staff told him and staff #3 the police would be called if his behavior did not stop. He exited the bowling alley before police were called. The report indicated client #2 was now banned from the bowling alley. An UIR dated 10/16/14 indicated client #2 "stole" [staff #6's] drink, and client #2 lost a computer video opportunity "per his plan." Client #2 was "upset about losing a video," and "starting drawing his hand back as though to hit staff....[Client #2] grabbed [client #1] by arm (sic) and dug finger nails in.....[client #2] left welts on [client #1's] arm and scraped a small amount of skin. Marks and welts were still present over an hour later." There was no evidence the incident was reported to BDDS or investigated. The NDQ was interviewed on 10/28/14 at			

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	5:05 PM. She indicated the Team Manager (TM) was no longer working in the group home. She stated the TM "had inappropriate behavior during an incident with [client #1], and left (employment) last night. It wasn't a good fit." She stated the TM was to leave on 10/31/14, "but left today instead." She indicated client #1 had a behavioral incident yesterday with staff #2. She indicated client #1 was with the QAD for a community outing. Staff #2 was interviewed on 10/28/14 at 5:08 PM. When asked about the incident with client #1 she stated, "We got through it." She stated the QAD was in the group home "occasionally." The QAD was interviewed on 10/28/14 at 5:25 PM. When asked about reportable incidents to the BDDS office, he indicated they would be available in the morning and stated, "There are a lot of them." Staff #3 was interviewed again on 10/29/14 at 6:50 AM. She indicated she had never seen the TM use inappropriate CPI, but stated "I did see him being more persistent than necessary in trying to get the guys to do stuff." She indicated client #2 also had an earning program for computer use and indicated if client #2 took something that was not his, he			

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	would lose an opportunity for using the computer. If he returns the item, he can re-earn the use of the computer. She indicated client #2 used laminated pictures of computers as a visual aid to earning the computer time. She indicated she was with client #2 at the bowling alley when he attempted to drink beer and stated, "I was right behind him." When asked about overnight staff, she stated, "They've discontinued 2 overnights (staff) since last Wednesday. They asked everyone if they felt comfortable. These guys once they're asleep, they're asleep. I was by myself last night." She indicated the overnight staff stayed until clients #2 and #3 left for the day. She indicated the clients usually were asleep by 8:00 PM and stated "By 10:00 PM everyone is asleep." She indicated the overnight staff worked from 8:00 or 10:00 PM until 8:00 AM. The QAD was interviewed on 10/29/14 at 12:30 PM. When asked about the investigation in regards to the TM using a CPI escorted walk with client #1, he indicated the Director of Support Services (DSS) had completed the investigation. He indicated the TM had worked in the group home under the supervision of administrative staff until the investigation had been completed. He stated the TM had not been using the CPI			

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	techniques with client #1 as a "last resort, but to gain compliance." He indicated the TM did not follow client #1's plan. The Behavior Specialist (BS) was interviewed on 10/29/14 at 12:40 PM and when asked how frequently she visited the home, she stated, "As behaviors are better, I'm available via phone. I come one time weekly and take phone calls from parents and staff. (I complete) random visits as part of our rotation (of monitoring)." The facility's reportable incidents to the BDDS since 9/26/14 were reviewed on 10/29/14 at 12:38 PM and included the following: 1. A BDDS report dated 9/26/14 at 4:10 PM indicated client #1 was at the dinner table eating chicken when he made the statement "the bone looked like poop. He began obsessing over it...and began to target [client #2] and grabbed the back of his shirt...He began laughing loudly in [client #2's] ear. [Client #1] left the room then went after the roommate (client #3) again and scratched his neck. [Client #1] found a butter knife in the kitchen and said he was going to stab [client #2]. Staff removed the butter knife and took housemates to the back porch. Staff called the house manager for assistance.			

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	While waiting outside [client #1] pulled the fire alarm." Corrective action indicated a peer-to-peer investigation would be completed. A BDDS report dated 9/26/14 at 5:30 PM indicated client #1 "was in a drawn out behavior when he pulled the fire alarm. The alarm security company called the group home and staff acknowledged that there was no fire but emergency services came anyway. They toured (sic) the house to confirm there was no fire and left." Corrective action indicated "Staff will address the issue of [client #1] continuing to pull fire alarms at the staff meeting on Monday morning (9/26/14). The Team Manager (TM) and QAD (Quality Assurance Director) will make contact with the alarm company and confirm the protocol for calling off false alarms." A BDDS report dated 10/1/14 at 12:30 PM indicated client #1 started yelling "wiener" and "hysterically laughing...On arrival, one staff took the other two clients into the bowling alley to bowl while the other staff stayed in the van with [client #1] trying to calm him down." When he was calm, client #1 went into the bowling alley and played video games in the arcade. When client #1 ran out of money, he started			

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	"ruminating about Oktoberfest, how his toy he won looked like poop, and the word 'penis'." After calming down he recognized an individual from another group home and begin "flipping her off and yelling about how his toy looked like her poop." Staff helped the other two clients finish bowling then they all headed home. "On the way home, [client #1] grabbed and hit [client #2], then threw objects at him. Staff had [client #2] move to the back of the van away from [client #1] and while doing so [client #1] tried to poke [client #2] with a hula hoop." Corrective action indicated an "IDT meeting will convene today to discuss the incident and develop plan of action for [client #1's] continued aggression." A BDDS report dated 10/22/14 at 9:00 AM indicated client #1 "was outside with staff when he saw some girls from the neighborhood and began to make kissing noises. [Staff #2] asked [client #1] if this was an appropriate noise and [client #1] said no. He continued to make kissing noises. [TM] told [client #1] if he did not stop acting inappropriately [client #1] would be led on a walk. [Staff #2] went inside the home to assist other individuals. [TM] took [client #1] on a walk around the neighborhood. [Client #1] told [staff #2] it was a CPI (Crisis			

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	Prevention Institute) walk and this was confirmed by [TM]. Later [TM] took [client #1] on a few more CPI walks in the backyard of the home throughout the evening. [Staff #2] walked with [client #1] and he willingly held her hand while walking and talking to her. At no point was [client #1's] behavior aggressive." Corrective action indicated "an investigation into potential abuse is underway." A BDDS report dated 10/26/14 at 8:25 PM and reported on 10/28/14 indicated client #1 came out of his room after going to bed and told [staff #4] "'You choked me. I am going to call the cops.' [Staff #3] returned the (sic) when [staff #4] called her to assist. Calls by [staff #1], [staff #4] and [staff #3] to on call and cell of [TM] went unanswered. [Staff #3] had [staff #4] step out of [client #1's] sight and worked with continuing behaviors until 10:05 PM when [client #1] fell asleep." Behaviors included client #1 going into client #2's room and running toward client #2 in bed. "A CPI escort was necessary to remove [client #1] from [client #2's] room. [Client #1] then pounded on [client #2's] door, turned the thermostat up to 99 degrees and then down to 22 degrees all in an attempt to bother [clients #2 and #3]. [Client #1] engaged in obsessive thought patterns			

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	about pulling the fire alarm. [Staff #3] redirected [client #1] each time. When [client #1] decided to pull [client #3] out of bed, [staff #3] blocked him and re-directed him to bed. [Client #1] finally laid down on his bed and asked [staff #3] for reassurance she was on his side. [Staff #3] answered that she was there to support him. [Staff #3] rubbed [client #1's] back for 20 minutes until [client #1] fell asleep." Corrective action indicated "Review actions of on call and supervisor [TM] to see if failed (sic) to provide support to [client #1] and staff. Add additional staff to Ridgeview roster. Review [client #1's] recent rash of behaviors." There was no evidence the allegation that client #1 made that staff #4 had choked him was investigated. A BDDS report dated 10/27/14 at 9:45 PM indicated "[client #1] got out of bed and asked where the overnight person was because he wanted to tease her. [Staff #2] worked with [client #1] to calm him down so he could go back to bed. [Client #1] insisted on staying up and was yelling inappropriate words trying to wake up other consumers. [Client #1] spoke with [relative] twice during the behavior. [Relative] tried assist (sic) with calming down and going to sleep. [Client #1] asked to talk to [QAD] after his second call to [relative].			

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	[QAD] and [client #1] discussed fishing and things that make [client #1] happy. [Client #1] then got his ventriloquist dummy and started making inappropriate gestures and saying inappropriate things. [Client #1] calmed down and gave [staff #1] the dummy and his pirate hat in the office. [Staff #2] rubbed [client #1's] arms and hands upon [client #1's] request and as approved for calming [client #1] until [client #1] was ready for sleep." Corrective action indicated "IDT will convene to discuss the incident and develop a plan of action for [client #1's] continued aggression." There was no evidence in the BDDS reports provided that the incident detailed in the UIR dated 10/4/14 involving client #1 going to the neighbor's house, ringing their doorbell or of client #1 exposing himself to the neighbors, or of client #1's escort off neighbor's property was reported to BDDS. There was no evidence in the BDDS reports provided that the incident detailed in the UIR dated 10/5/14 in which client #1 went to the neighbor's house and rang their doorbells was reported to the BDDS office. There was no evidence in the BDDS reports provided that the incident detailed			

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	in the UIR dated 10/27/14 at 2:30 PM until 6:00 PM regarding client #1's behavior was reported to BDDS, including client #1 "threatening to hit some of the other individuals" with a measuring spoon he used beat on the counter, and placing the spoon in the microwave to heat up. Client #1 asked if he could get a butter knife and hurt people with it, and client #1 made kissing noises at the neighbors, went to the neighbor's doors and "attempting to ring the doorbell and flip them off." Client #1's BSP dated September, 2014 was reviewed on 10/28/14 at 6:04 PM. Targeted behaviors included Enuresis/Encopresis (urinating and bowel movements intentionally occurring when not in the bathroom), calling 911, physical aggression (hitting, spitting, touching staff in private areas, throwing objects at others), verbal aggression (name calling, making threats towards others, asking others if he can cause harm to them). The plan indicated "Reactive strategies for verbal aggression indicate that staff should only engage in conversation with [client #1] if he's talking about topics that are calming, and to return to proactive strategies when calm...Reactive strategies for physical aggression state that if [client #1] is physically aggressive and it escalates to a			

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	level where he or others appear to be in eminent danger, staff may need to use the appropriate physical intervention technique (CPI) for each unique situation in order to keep [client #1] and staff safe." There was no indication of which CPI techniques to use or hierarchy for their use. The BSP did not include physical interventions as a reactive strategy for verbal aggression. For client #2: 2. A BDDS report dated 10/4/14 at 1:00 PM indicated client #2 "tried to force" client #3 to drink lemonade. Staff #3 intervened, but client #2 "tried to choke her and hit her in the back." The report indicated "Writer" (unidentified) used an interim position hold to remove [client #2] from the area and walk him to his room. [Client #2] threw blankets at writer until writer kept them all. Writer told [client #2] that if he continued to "try to hit" he would not watch his videos on the computer. [Client #2] took a VHS tape from his closet and raised it to strike writer. Writer told [client #2] if he hit him he would lose all his tapes. [Client #2] put his VHS back and said B-A-M-B-I.' Writer replied 'If you want to watch Bambi as one of your videos you need to put all the blankets back on your bed and write your list.' [Client #2]			

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	complied. Writer noted a small finger/thumb print on the right side of [staff #3's] neck...This behavior lasted approximately 10 min (minutes)." Corrective action indicated "Review BSP and adjust actions accordingly." A BDDS report dated 10/4/14 at 2:30 PM indicated client #2 went bowling in another city. "Right before it was time to leave the bowling alley [client #2] walked over to the bar at the alley with staff right behind him. [Client #2] grabbed a cup and tried to pour himself a beer from the tap. Staff dumped it out and [client #2] continued to try and get more cups. Staff attempted to redirect [client #2] but [client #2] kept saying 'one beer'." Staff said 'no beer' and [client #2] attempted to drink out of the tap itself. [Client #2] had a strong grip on it and was spilling beer on the floor. The second staff arrived at this point and got [client #2] out from behind the bar. [Client #2] then fell to the floor and began yelling and banging his hands on the floor. A Special Olympics staff then told Ridgeview staff and [client #2] that if this continued they would have to call the police. After repeating this to [client #2] a couple of times he stopped and then calmed down and left with staff." Corrective action indicated "Emergency IDT will convene today to discuss the			

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	incident and determine measures to address the incident." A BDDS dated 10/18/14 indicated client #2 "opened the office and drank writer's (unidentified) coffee...One staff took one of [client #2's] videos off of his picture chart. Staff explained why he lost the video-for stealing." Client #2 began to "get upset and began to yell that he wanted 'F-I-V-E'!" Client #2 "dug his nails" into writer's arm, then took a quarter and began hitting the writer in the arm with the quarter. Client #2 grabbed the arm of unidentified staff and threw change, hitting writer. Writer collected the money and gave it to staff. This caused client #2 "to begin yelling about money." Client #2 was given the money when he calmed down. Corrective action indicated "Continue to document negative behaviors and follow BSP. A BDDS report dated 10/26/14 indicated client #2 "has been taking food from glass containers and dumping them out in order to recycle. [Client #2] was asked not to dump the food and he lost a video off of his chart. [Client #2] was upset and crying about losing the video. [Client #2] grabbed writer's (unidentified) arm and [staff #3's] arm and left a mark. [Client #2] then proceeded to open and close the patio door, slamming the door hard			

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	enough to break the key off in the door." Corrective action indicated "Continue to follow BSP." Client #2's record was reviewed on 10/29/14 at 8:46 AM. A BSP dated 9/14/14 included target behaviors of physical display of frustration (screaming, crying, jumping up and down and yelling 'no'), physical aggression (kicking, slapping, pinching, hitting with objects), PICA (ingesting non-edible items such as paper, grass, dog food, raw meat, pen caps, hair bands, pencil erasers, etc), taking food/drinks (taking food or drinks from others or any food/drink sitting out), public masturbation (touching genital area when in public or around others). The interventions for the targeted behaviors did not include the removal of videos or of watching videos on the computer. 3. A BDDS dated 9/26/14 indicated client #3 was "very agitated when he woke up in the morning around 5:45 AM. He has a history of 'cycling' where he becomes increasingly agitated and it leads to outbursts of aggression. The previous day the Human Rights Committee had approved a prescribed PRN (as needed) for just such instances. Staff tried all the proactive measures written in his protocol to try and calm him down. They			

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	did not succeed and as he became increasingly agitated the [Team Manager] called [LPN] (licensed practical nurse)], and agency nurse, at 6:30 AM and described the situation. She recommended the use of the PRN Ativan. It was administered per protocol and [client #3] was monitored and encouraged to relax. He lay on the couch and watch a favorite movie. Staff said he seem (sic) to calm down a bit but still showed signs of agitation." Corrective action indicated the team manager will continue to monitor and follow protocol as written and provide feedback to the director of quality assurance and the LPN. A BDDS report dated 9/26/14 at 12:30 PM indicated client #3 required an additional PRN medication as he "continued to become more agitated as the day progressed, pacing and rubbing his hands together in the way that commonly precedes such acts of aggression..." Corrective action indicated client #3's response to the PRN medication was monitored. A BDDS report dated 9/26/14 at 7:18 PM indicated client #3 was looking at videos on his electronic tablet and client #2 came into the room and attempted to take it from him. Client #3 then "gravved (sic)			

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	[client #2] and left a red ring around his neck and ripped his shirt fighting him to get his ipad back. When staff (unidentified) went to separate the two [client #3] grabbed her (staff) and removed her shirt and bra as well." The report indicated the house manager restrained client #3 and held him on the ground for a minute until he was calm. Corrective action indicated a peer to peer investigation would be completed. Client #3's BSP dated September, 2014 was reviewed on 10/29/14 at 8:40 AM. Targeted behaviors indicated physical aggression (pulling shirt off of others), self injurious behavior (rubbing fingers together until they are raw), elopement (climbing out of windows, running away from staff). The plan included the use of Vistaril 25 mg (milligrams) as needed for insomnia and Ativan .5 mg one tablet by mouth every 6 hours as needed for agitation. The plan indicated for physical aggression "if [client #3] continues to be physically aggressive and it escalates to a level where he or others appear to be in imminent danger, staff may need to use the appropriate physical intervention technique (CPI) for each unique situation in order to keep [client #3] and the staff safe." There was no indication of which CPI techniques to use or hierarchy for their use.			

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	Staff #3 and staff #1 were interviewed on 10/29/14 at 8:30 AM. When asked about the incident dated 10/26/14 in which staff #3 she was called back to work after leaving for the night, staff #3 stated, "Everything was quiet when we left," and client #1 "was on his way to sleep." Staff #3 stated, "He's been known to get up after being asleep for an hour." Staff #1 indicated she took staff #3 to her car and staff #3 indicated staff #4 was alone with client #1 "a half hour or less." Staff #1 and #3 indicated they were unable to reach the TM who was on call to address the sta ffing needs of the home. Continuing Education Records were reviewed on 10/30/14 at 11:50 AM and included the following: 9/22/14: ".... TM talked about staffing; [Staff #4] wants to move to another location; uncomfortable working alone overnight...." 9/24/14; TM was trained on BDDS reporting; how to complete and what are reportable incidents. 9/29/14; indicated the TM, staff #4, staff #2, staff #6, staff #3 and the QAD were present for training on clients #1, #2 and			

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	#3's BSPs. 10/6/14; indicated the TM, staff #6, staff #2, staff #3 and staff #4 were trained regarding BSP competency evaluations for clients #1, #2 and #3. 10/13/14 indicated new goals for clients #1 and #2 were reviewed, and the schedule for the next two weeks was reviewed. 10/22/14 Team meeting notes indicated with staff #7, TM and NDQ present indicated "Staff is not to have drinks, coffee and soft drinks especially in the house of the customers. It was emphasized that this is the customer's home and we all know that some customers takes (sic) and either gulp them or give them to another customer. If this happens, staff needs to review their own behavior and how it affected the situation....On call pager: [NDQ] stated that the on call pager is assigned from Monday to Monday." 10/22/14; group home meeting indicated staff #1, #3, #5, and the TM were trained regarding medication administration. Minutes indicated the BS had provided training for client #2's goals, and use of a choice board.			

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	10/29/14 group home meeting minutes indicated staff #1, #2, #3, #5, the group home nurse, the NDQ and the BS were present at the meeting conducted by the QAD. The minutes indicated a review of goals for clients #1, #2, and #3, thoroughly completing progress notes, "Please keep drinks in your car!,...[client #1's] new behavioral PRN order-[nurse] working with (sic) the doctor to figure out a solution." Notes attached to the minutes indicated staff #3 would be working alone overnight from Monday through Thursday, all day on Saturday and Sunday and staff #4 would work overnight from 10:00 PM to 6:00 AM. There was no evidence of staff training regarding client #1's behavior plan and the use of CPI techniques, or of reporting abuse, neglect and mistreatment requirements. IDT meeting minutes dated 10/5/14 regarding the 10/4/14 incidents involving clients #1 and #2 on 10/4/14 were reviewed on 10/28/14 at 5:45 PM and indicated the following recommendations: 1. "Behavior specialist (BS) following up with [client #1's] psychiatrist about a behavioral PRN (as needed medication). 2. "Adjust [client #1's] earning program to lengthen or change the period of earning."			

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	3. "Speak with [clients #3 and #1's] families about scheduling visits further in advance." 4. "Consider writing drink seeking component to [client #2's] behavior plan." 5. "Reminding staff that rubbing [client #1's] back helps in calming him down." 6. "Have [staff #7] stay today until [client #1] wakes up to help with potential behaviors." 7. "Have someone (BS, staff #7, or Quality Assurance Director (QAD) follow up with the neighbors." 8. "QAD is available as backup staff for this evening if behaviors continue." Emergency IDT meeting minutes for the 9/26/14 incident were reviewed on 10/30/14 and indicated the following: For client #1: -"Reminding all visitors to moving to the office (sic) and shutting the door during behaviors" -"Re-directing [client #1] either to his room, a car ride, or a walk" -"Moving other customers and staff away from the immediate vicinity" -"Build potential loss of extra activities into earning program for negative behavior" For client #2: -"Getting [client #2] his own computer-set up in living room, set times			

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	of day, make a goal" -"Encourage writing instead of printing" For client #3 -"Ativan PRN seemed to help during the day" -"Encouraging [client #3] to use his ipad in his room (not restricting, just encouraging him) -Assuring staff are in the living room with the guys whenever more than one is in there" IDT meeting minutes dated 10/24/14 were reviewed on 10/30/14 at 5:10 PM and indicated "staff said they are comfortable with just a single staff. The only note was that if there were behaviors actively going on it would be helpful if a second overnight (sic) would be called in Per Required Need....The QAD suggests implementing a protocol where if one of the residents are actively exhibiting behaviors into the evening shift then one of the two evening shift staff would stay until midnight to make sure they are available for behavioral support. If behaviors are still occurring as it approaches midnight then staff will call in a second overnight (aka PRN overnight). CEO (Chief Executive Officer) and Direct Support Services agree that this plan is reasonable since the			

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	second overnight hasn't been needed so far and it still addresses future/potential behaviors." There was no indication in the meeting minutes of an investigation or corrective action/preventive steps in regards to the incidents dated 10/5/14, 10/26/14 and 10/27/14 regarding client #1's behavior, or of the incident dated 10/16/14 regarding client #2's behavior. Investigations were reviewed on 10/30/14 at 5:10 PM and indicated the following: An investigation dated 9/29/14 into the incident dated 9/26/14 indicated client #1 scratched client #2's neck and pulled his shirt, and pulled the fire alarm. Recommendations indicated "Group home staff and IDT should meet to de-brief the situation and discuss the effectiveness of the behavior plan, as well as both proactive and reactive techniques that could have helped the situation. The agency's Behavior Specialist should be consulted to determine if changes to the plan need to be made. Findings should be forwarded to the CEO, DoSS (Director of Support Services) and QAD for review." An investigation dated 10/5/14 and completed 10/5/14 indicated client #1 had been "upset at the bowling alley and			

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	chose not to bowl. He had been upset about coming home early from a visit with his mother. At the alley he began to ruminate about 'Oktoberfest,' how his toy looked like poop, and the word 'penis'. On the drive home, [client #1] grabbed [client #2's] shirt and threw undefined 'objects' at him. Staff had [client #2] move to the back of the van and sat between them, but [client #1] used a hula hoop to try and poke [client #2]." Recommendations indicated "The behaviors are addressed in [client #1's] behavior plan, but the incidents from the day should be discussed with an IDT de-briefing to occur within two days. Any further findings and recommendations should be forwarded to the DSS (Director of Support Services) and CEO." An investigation initiated 10/23/14 indicated on 10/20/14, the TM took client #1 for a walk around the neighborhood. Client #1 told [staff #2] it was a "CPI walk," and this was confirmed by the TM. "Later the [TM] took [client #1] on a few more 'CPI' walks in the backyard of his home. [Staff #2] reported at no point was [client #1's] behavior aggressive. This report is being investigated as an allegation of violation of rights: failure to implement the behavior support plan and improper use of physical restraint." Statements indicated the QAD			

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	interviewed client #1 and client #1 "told [QAD] that they were raking leaves and he made kissing noises at the neighbor, so [TM] did CPI. [Client #1] said that made him feel angry, sad, scared and embarrassed. [Client #1] demonstrated on [QAD] how [TM] did a 'discipline walk,' by grabbing [QAD] with both arms and moving him. [Client #1] indicated there were lots of 'CPI' walks and he didn't like it...." The NDQ's statement indicated client #1 indicated to her the "CPI walks...happened no less than 5 times and he did not like CPI." The investigation indicated the unusual incident report indicated the date of the incident was 10/20/14, but the UIR (Unusual Incident Report) was 10/23/14. The QAD confirmed the date was in error and had occurred on 10/20/14. Progress notes reviewed in the investigation indicated client #1 had "NB's (not defined) from 4:30 -8:30 PM...Writer (TM) walked [client #1] each time he exhibited NB's'." (sic). Client #1's BSP was reviewed for the investigation and indicated "Reactive strategies for verbal aggression indicate that staff should only engage in conversation with [client #1] if he's talking about topics that are calming, and to return to proactive strategies when calm...Reactive strategies for physical aggression state that if [client #1] is physically aggressive and it escalates to a			

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	level where he or others appear to be in eminent (sic) danger, staff may need to use the appropriate physical intervention technique (CPI) for each unique situation in order to keep [client #1] and staff safe." The investigation indicated the allegation was "substantiated," and "Based on all the information available, including [TM's] documented account of the incident, it does appear [TM] violated [client #1's] rights by using a CPI hold when [client #1] was exhibiting verbal aggression, even though he was not a danger to himself or others." Recommendations indicated the behavior specialist "should provide additional training to staff to ensure all understand [client #1's] behavior support plan, and when it is appropriate to use physical intervention (only when [client #1] presents an eminent danger to himself or others." The investigation indicated it was completed on 10/27/14. There was no indication in the investigations provided of corrective action/preventive steps in regards to the incidents dated 10/5/14, 10/26/14 and 10/27/14 regarding client #1's behavior, or of the incident dated 10/16/14 regarding client #2's behavior. The Quality Assurance Director (QAD) was interviewed on 10/31/14 at 11:47			

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	AM. He indicated the incident dated 10/20/14 had not been reported timely, and indicated the TM had continued to work in the group home after the incident where he used CPI escort as to gain compliance for client #1 on 10/20/14. He indicated the TM did not work alone, and was under the supervision of the NDQ. He stated, "In hindsight, he shouldn't have worked" until the investigation into the incident was completed. He indicated he was aware of the incidents on 10/4/14 and on 10/5/14 in which client #1 called police, attempted to grab police officers, exposed himself to police and neighbors, and rang neighbor's doorbells. He indicated the incidents had not been reported to BDDS as the NDQ was new to the position and still learning how to file reports. He indicated the incident dated 10/26/14 in which client #1 stated staff #5 had choked him was not investigated. He indicated staff had been trained on reporting requirements after each incident during weekly group home meetings, but the training was verbal and not documented. He indicated the incident dated 10/1/14 regarding client #1's behavior at the bowling alley was in error and the incident occurred on 10/4/14. He indicated the incidents of physically aggressive behavior between clients were not always formally investigated, but each incident went			

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	through a de-briefing process at the weekly team meetings to discuss proactive steps to take to prevent future occurrence. He indicated the group home staff were now working closely with client #3's school to prevent re-occurrence of client #3's physically aggressive behavior, but had not yet implemented an intervention to address client #3's property destruction. The DoSS (Director of Support Services) was interviewed on 11/3/14 at 4:50 PM and stated she was uncertain as to the definition of "NB" as indicated in the TM's documentation of the incident on 10/20/14. The facility's Reporting of Abuse and Neglect dated 9/13 was reviewed on 10/30/14 at 1:11 PM and indicated all incidents of abuse and neglect would be reported and investigated. The policy indicated the investigation process would include "A resolution for the investigation including recommended actions and policy/procedure changes." This deficiency was cited on September 12, 2014. The facility failed to implement a systemic plan of correction to prevent reoccurrence. 9-3-2(a)			

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W000153	483.420(d)(2) 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. Based upon record review, and interview,	W000153	Incidents referenced for client #1 that occurred on 10/4/14 and 10/27/14 were not originally	12/03/2014

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	the facility failed to timely report 2 of 2 allegations of abuse involving client #1, and 5 of 7 incidents of verbally and physically aggressive behavior and sexually inappropriate behavior involving client #1. The facility failed to report 1 of 2 incidents of physically aggressive behavior involving clients #1 and #2 in accordance with state law. Findings include: Unusual Incident Reports (UIRs) were reviewed on 10/28/14 at 6:30 PM and included the following reports: For client #1: An UIR dated 10/4/14 at 1:00 PM indicated client #1 was brought back early from a visit with a relative to attend a Special Olympic bowling event. On the way to the event, client #1, "yelled wiener", calmed down, then went into the bowling alley to play video games. Once his money was gone, client #1 "flipped off" (profane gesture) staff from another group home. The incident report indicated during the incident client #1 hit and grabbed client #2, and upon returning home, "walked around the house kicking the house and banging on windows. When [client #1] saw that staff wasn't reacting to him beating on the house		reported to BDDS because they do not meet the defined reporting criteria per DDRS Incident Reporting Policies; however, in order to correct the deficient practice, BDDS reports will be completed for those incidents. There was a short period of time in October when interfering behaviors increased in frequency,resulting in some late reporting. Behaviors have since decreased. To correct the deficient practice and prevent it's recurrence, all staff have been retrained on the requirement to report all allegations immediately. All staff have access to a scanner/ e-mail in the home, and have been instructed to scan & e-mail all Unusual Incident Reports to the ND/Q, Director of Residential Services (DORS) and Director of Support Services (DOSS) to ensure information is shared timely, and necessary action is taken right away. A reminder has also been posted on the AccelTrax system, the electronic system that all LifeDesigns staff utilize to report time and progress notes at the end of each shift. All supervisory staff will be retrained on all policies/ procedures related to incident reporting and investigations, including the importance of timely reporting, ensuring staff are suspended when abuse/ neglect has been alleged, and thorough documentation of all resulting	

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	windows, he went to the neighbors house," rang their doorbell and attempted "to beat on" the neighbor's windows, but was redirected by staff. Client #1 "ruminated" about the police being called (no indication police were called in the report) and whether the neighbors would call police. Client #1 remained on their porch for an hour until the TM (Team Manager) on call arrived and escorted client #1 off the neighbor's property. Client #1 then tried to go to another neighbor's house, but was redirected, and continued to make "rude remarks and obscene gestures throughout the entire evening." After client #1 returned to the group home, he opened his bedroom window, "several times" pulled down his pants and "flipped off" the neighbors. Client #1 "eventually calmed down," then went on a van ride with clients #2 and #3 and 2 overnight staff. The report indicated the incident did not require investigation. An UIR dated 10/5/14 (time not indicated) indicated while staff (unidentified) was preparing breakfast and staff #5 was preparing medications for administration, client #1 asked if staff #5 was going to "call the cops" or if neighbors would call the cops. Client #1 called the police from the group home office and when they arrived, client #1		corrective action. The ND/Q will be in the home no less than twice weekly, in addition to weekly team meetings, in order to provide ongoing monitoring. Additionally, the DORS will be on-site no less than monthly, and the CEO will complete a quarterly on-site visit to review the overall setting and documentation. Additional ongoing monitoring will be completed by the Services Leadership team, who meet at least twice a month to review all BDDS reports and investigations.	

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	"exposed his genitals" to police and tried to "grab" them as they left. The report indicated during the conversation between client #1 and police "that it was inappropriate to prank call police and next time it might not just be a talking to." Client #1 sat in the office with staff #5 and "ruminated on calling the police, going to Oktoberfest, getting neighbors to call the police." Client #1 "proceeded to try and exit residence stating that he was going to make them 'call the cops'." There was no indication client #1 left the group home during the incident. Client #2 went on an outing and client #3 went home while staff #5 stayed with client #1. There was no evidence the incident involving client #1 calling police, exposing his genitals or attempting to grab the police upon their exit from the home was reported to the BDDS office. An UIR signed on 10/23/14 completed by the TM indicated on 10/20/14 at 4:30 PM indicated "Duration of behavior, 4 hours." Client #1 saw neighbor kids and made "kissing noises and taunts...DSP (Direct Support Professional) tried verbal redirection." Writer (TM) intervened and prompted [client #1] to take a walk. [Client #1] complied. [Client #1] returned to home (sic) and continued making inappropriate comments/verbally aggressive. TM and DSP attempted			

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	verbal redirection, active ignoring, and proactive measures using careplan, but [client #1] continued. TM physically prompted [client #1] to take a walk by placing his hand on [client #1's] back. [Client #1] walked w/ (with) TM, but became agitated when a dog barked at him. When TM and [client #1] returned, TM prompted [client #1] to call his [relatives]. [Client #1] made verbal threats re: dog and others. TM directed [client #1] to take another walk, but [client #1] refused. [Client #1] dropped in the middle of the street and refused to walk. TM stood nearby as [client #1] made threats at neighbors who passed, yelling "F___you," and "Can I kill you?" Client #1 also pulled his pants down while in the street. The TM "physically prompted [client #1] to roll to his side then stand and return to the house." Client #1 went to his room, then left his room, "and continued to be verbally aggressive, threatening staff/TM asking, "Can I kick you,"Can I spit on you," and "Can I bite you?" Client #1 was directed to use his emotions chart in his room, and "[client #1] followed TM and [staff #2] prompted client #1 to walk in the back yard. [Client #1] complied. When overnight staff #4 arrived to work in the home at 8:00 PM, she waited for client #1 to return to his room. Client #1 returned to his room, and staff #2			

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	"stopped him from reaching [staff #4] (whom he was targeting)." Client #1 "continued to make threats, asking 'Can I pick on [staff #4]?'" TM "physically prompted [client #1] to continue his walk using [physical hold/escort technique]. [Client #1] walked w/ TM though he attempted to bite, kick, and spit on TM. When [client #1] finished his walk he went to his bed @ (at) 8:30 PM and remained there for the rest of the evening." An UIR dated 10/27/14 indicated "Duration of behavior; 1 hour, 45 minutes." Client #1 asked staff if he could get a butter knife and hurt people with it. Client #1 made kissing noises at the neighbor's house and "ruminated" regarding calling the cops and having CPI used on him. Client #1 beat on the counters with a metal spoon and "threatened to hit some of the other individuals with it." Client #1 "mentioned to [staff #2] that he was acting like this because he had anxiety about the TM's being here because he didn't want to be CPI escorted anymore." When the TM came to the group home, client #1 "started asking the TM if he was going to do CPI on him." Client #1 went to one of the neighbor's houses and "attempted to ring the door bell and flip them off." Client #1 asked if the			

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	neighbors would call the police, and was redirected off the neighbor's property. While walking from the neighbor's property client #1 "decided to go on another neighbor's property and attempt to ring their doorbell and upset them." The group home nurse, NDQ (Network Director/QIDP (Qualified Intellectual Disabilities Professional), and staff #1 and #2 were able to redirect client #1 back to the group home and client #1 assisted staff #2 in making dinner. "When the TM came in with the other individuals, [client #1] started getting worked up again. He went into the living room where individual [client #3] was trying to watch a movie and started sticking that individual's exercise band in his mouth in an attempt to upset [client #3]. He was also mocking the [TM] a lot." Staff #2 redirected client #1 back to his room and talked to him about why he was getting himself worked up again after he had just calmed down. [Client #1] told [staff #1] that he still had anxiety about the [TM] and being CPI escorted....." The report indicated the incident was reported to BDDS and would be investigated. There was no evidence of corrective action in the report. For client #2:			

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	An UIR dated 10/16/14 indicated client #2 "stole" [staff #6's] drink, and client #2 lost a computer video opportunity "per his plan." Client #2 was "upset about losing a video", and "starting drawing his hand back as though to hit staff....[Client #2] grabbed [client #1] by arm (sic) and dug finger nails in.....[client #2] left welts on [client #1's] arm and scraped a small amount of skin. Marks and welts were still present over an hour later." There was no evidence the incident was reported to BDDS or investigated. The QAD (Quality Assurance Director) was interviewed on 10/28/14 at 5:25 PM. When asked about reportable incidents to the BDDS office, he indicated they would be available in the morning and stated, "There are a lot of them." The facility's reportable incidents to the BDDS office since 9/26/14 were reviewed on 10/29/14 at 12:38 PM and included the following: 1. A BDDS report dated 10/1/14 at 12:30 PM indicated client #1 started yelling "wiener" and "hysterically laughing...On arrival, one staff took the other two clients into the bowling alley to bowl while the other staff stayed in the van with [client #1] trying to calm him down." When he was calm, client #1			

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	went into the bowling alley and played video games in the arcade. When client #1 ran out of money, he started "ruminating about Oktoberfest, how his toy he won looked like poop, and the word 'penis'." After calming down he recognized an individual from another group home and begin "flipping her off and yelling about how his toy looked like her poop." Staff helped the other two clients finish bowling then they all headed home. "On the way home, [client #1] grabbed and hit [client #2], then threw objects at him. Staff had [client #2] move to the back of the van away from [client #1] and while doing so [client #1] tried to poke [client #2] with a hula hoop." A BDDS report dated 10/22/14 at 9:00 AM indicated client #1 "was outside with staff when he saw some girls from the neighborhood and began to make kissing noises. [Staff #2] asked [client #1] if this was an appropriate noise and [client #1] said no. He continued to make kissing noises. [TM] told [client #1] if he did not stop acting inappropriately [Client #1] would be led on a walk. [Staff #2] went inside the home to assist other individuals. [TM] took [client #1] on a walk around the neighborhood. [Client #1] told [staff #2] it was a CPI (Crisis Prevention Institute) walk and this was			

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	confirmed by [TM]. Later [TM] took [client #1] on a few more CPI walks in the backyard of the home throughout the evening. [Staff #2] walked with [client #1] and he willingly held her hand while walking and talking to her. At no point was [client #1's] behavior aggressive." Corrective action indicated "an investigation into potential abuse is underway." A BDDS report dated 10/26/14 and reported 10/28/14 indicated client #1 came out of his room after going to bed (time not identified) and told staff #4 "You choked me. I am going to call the cops." The report indicated staff #3 returned to the home after calls to the on call TM went unanswered. A CPI escort and block was used to prevent client #1 from going into client #2's room during the incident. There was no indication why the incident was reported to the BDDS office on 10/28/14. There was no evidence in the BDDS reports provided that the incident detailed in the UIR dated 10/4/14 involving client #1 going to the neighbor's house, ringing their doorbell or of client #1 exposing himself to the neighbors, or of client #1's escort off neighbor's property was reported to BDDS.			

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	There was no evidence in the BDDS reports provided that the incident detailed in the UIR dated 10/5/14 in which client #1 went to the neighbor's house and rang their doorbells was reported to the BDDS office. There was no evidence in the BDDS reports provided that the incident detailed in the UIR dated 10/27/14 at 2:30 PM until 6:00 PM regarding client #1's behavior was reported to BDDS, including client #1 "threatening to hit some of the other individuals" with a measuring spoon he used beat on the counter, and placing the spoon in the microwave to heat up. Client #1 asked if he could get a butter knife and hurt people with it, and client #1 made kissing noises at the neighbors, went to the neighbor's doors and "attempting to ring the doorbell and flip them off." The QAD was interviewed on 10/29/14 at 12:30 PM. When asked about the incident dated 10/20/14 in regards to the TM using a CPI escorted walk with client #1, he stated the TM had not been using the CPI techniques with client #1 as a "last resort, but to gain compliance." He indicated the TM did not follow client #1's plan. For client #2:			

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	2. There was no evidence of a BDDS report regarding the incident on 10/16/14 in which client #2 scratched client #1 during a behavioral incident. The Quality Assurance Director (QAD) was interviewed on 10/31/14 at 11:47 AM. He indicated the incident dated 10/20/14 and 10/26/14 had not been reported timely. He indicated he was aware of the incidents involving client #1 on 10/4/14 and on 10/5/14 where client #1 called police and exposed himself and rang neighbors doorbells, but the incidents had not been reported to BDDS as the NDQ was new to the position and still learning. He indicated the incident dated 10/1/14 regarding client #1's behavior at the bowling alley was in error and the incident occurred on 10/4/14. This deficiency was cited on September 12, 2014. The facility failed to implement a systemic plan of correction to prevent reoccurrence. 9-3-2(a)			

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W000154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based upon record review and interview, the facility failed to complete a thorough investigation into 3 of 7 incidents of physically aggressive behavior, and 1 of 2 allegations of abuse involving client #1, and failed to complete an investigation with corrective action into 1 of 2 incidents of physically aggressive by client #2 involving client #1. Findings include: Unusual Incident Reports (UIRs) were reviewed on 10/28/14 at 6:30 PM and included the following reports: For client #1: An UIR dated 10/26/14 from 8:25	W000154	Incidents of physical aggression, when those incidents did not involve aggression towards another customer, were not investigated, as these are not considered abuse towards another individual; however, in order to correct the deficient practice, those incidents will be further investigated.All incidents were debriefed in team meetings, and ways to prevent or respond in a better way were discussed. Staff taking notes will be re-trained to be diligent in including detailed records of all team discussions in order to maintain comprehensive documentation. All ND/Qs will be retrained to document the review of all incidents of aggression, including recommended corrective action, on the provided space on the back of the Unusual Incident Report form.Additionally,	12/03/2014

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	PM-10:00 PM indicated "Duration of the behavior 1 hour, 54 minutes." Staff #3 left at 8:25 PM along with staff #1 as client #1 was lying down in his room "and all residents were quiet and in their bed (sic). On call [TM Team Manager] had called staff back at 8:00 PM. Staff #1 talked to [TM] on phone then staff #1 informed me that TM told her that one of us had to stay until 10 PM (if there was an issue) even after [staff #1] made it clear that she couldn't ...and [staff #3's] car was being worked on so [staff #3] didn't have a way home. Staff #3 received a phone call from [TM] asking writer to come back because [staff #4] had called and asked [staff #5] to come in due to [client #1] coming out of his room and finding [staff #4] and (client #1) making the statement "You choked me, I'm going to call the cops. [Staff #5] claimed to have tried to reach [TM] by phone and pager but was unsuccessful. Staff did not successfully reach the on call [TM] after he called the house at 8:00 PM." Staff #3 arrived at the house at 8:34 PM, staff #4 stepped out of client #1's sight, and client #1 was directed into his room by staff #3. "Ten minutes later, [client #1] came out of room (sic), stating "Can I pick on [staff #4]?" [Client #1]...opened [client #2's] door and ran for [client #2's] bed. [Staff #3] used approved CPI escort to remove [client #1] from room and		an investigation will be completed for the incident that occurred on 10/26/14, in reference to client #1 indicating that staff choked him. To prevent the deficient practice from recurrence, staff have access to a scanner/e-mail in the home, and have been instructed to scan & e-mail all Unusual Incident Reports to the ND/Q, Director of Residential Services (DORS) and Director of Support Services (DOSS) to ensure information is shared timely, and necessary action is taken right away. All supervisory staff will be retrained on all policies/ procedures related to incident reporting and investigations,including the importance of timely reporting, ensuring staff are suspended when abuse/ neglect has been alleged, and thorough documentation of all resulting corrective action. The ND/Q will be in the home no less than twice weekly, in addition to weekly team meetings, in order to provide ongoing monitoring.Additionally, the DORS will be on-site no less than monthly, and the CEO will complete a quarterly on-site visit to review the overall setting and documentation. Additional ongoing monitoring will be completed by the Services Leadership team, who meet at least twice a month to review all BDDS reports and investigations.	

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	prevent [client #2] from coming to harm. Client #1 returned to his room and was asleep by 10:05 PM. There was no evidence of an investigation or of corrective action. An UIR dated 10/27/14 indicated "Duration of behavior; 1 hour, 45 minutes." Client #1 asked staff if he could get a butter knife and hurt people with it. Client #1 made kissing noises at the neighbor's house and "ruminated" regarding calling the cops and having CPI used on him. Client #1 beat on the counters with a metal spoon and "threatened to hit some of the other individuals with it." Client #1 "mentioned to [staff #2] that he was acting like this because he had anxiety about the TM's being here because he didn't want to be CPI escorted anymore." When the TM came to the group home, client #1 "started asking the TM if he was going to do CPI on him." Client #1 went to one of the neighbor's houses and "attempted to ring the door bell and flip them off." Client #1 asked if the neighbors would call the police, and was redirected off the neighbor's property. While walking from the neighbor's property client #1 "decided to go on another neighbor's property and attempt to ring their doorbell and upset them." The group home nurse, NDQ (Network			

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	Director/Qualified Intellectual Disabilities Professional), and staff #1 and #2 were able to redirect client #1 back to the group home and client #1 assisted staff #2 in making dinner. "When the TM came in with the other individuals, [client #1] started getting worked up again. He went into the living room where individual [client #3] was trying to watch a movie and started sticking that individual's exercise band in his mouth in an attempt to upset [client #3]. He was also mocking the [TM] a lot." Staff #2 redirected client #1 back to his room and talked to him about why he was getting himself worked up again after he had just calmed down. [Client #1] told [staff #1] that he still had anxiety about the [TM] and being CPI escorted....." The report indicated the incident would be investigated. An UIR dated 10/27/14 from 9:45 PM -11:30 PM indicated "Duration of behavior 1 hour and 45 minutes." Client #1 "got out of bed and asked where the overnight person was because he wanted to tease her." Staff #2 "went to help [client #1] calm down and go back to bed. [Client #1] insisted on staying up late and yelling inappropriate words trying to wake up the other consumers." Client #1 got his ventriloquist dummy and "started making inappropriate			

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	gestures and saying inappropriate things about the dummy." Client #1 called a relative twice and the QAD (Quality Assurance Director) and spoke about fishing before going back to bed. Staff #2 "rubbed [client #1's] arm and hand upon his request, and scratched his back until he was ready to go to sleep." There was no evidence of an investigation or corrective action in the report. For client #2: An UIR dated 10/16/14 indicated client #2 "stole" [staff #6's] drink, and client #2 lost a computer video opportunity "per his plan." Client #2 was "upset about losing a video", and "starting drawing his hand back as though to hit staff....[Client #2] grabbed [client #1] by arm (sic) and dug finger nails in.....[client #2] left welts on [client #1's] arm and scraped a small amount of skin. Marks and welts were still present over an hour later." There was no evidence the incident was investigated. The NDQ) was interviewed on 10/28/14 at 5:05 PM. She indicated the Team Manager (TM) was no longer working in the group home. She stated the TM "had inappropriate behavior during an incident with [client #1], and left (employment)			

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	last night. It wasn't a good fit." She stated the TM was to leave on 10/31/14, "but left today instead." Staff #3 was interviewed again on 10/29/14 at 6:50 AM. She indicated she had never seen the TM use inappropriate CPI, but stated "I did see him being more persistent than necessary in trying to get the guys to do stuff." The facility's reportable incidents to the BDDS since 9/26/14 were reviewed on 10/29/14 at 12:38 PM and included the following: 1. A BDDS report dated 10/26/14 at 8:25 PM and reported on 10/28/14 indicated client #1 came out of his room after going to bed and told [staff #4] "You choked me. I am going to call the cops." [Staff #3] returned the (sic) when [staff #4] called her to assist. Calls by [staff #1], [staff #4] and [staff #3] to on call and cell of [TM] went unanswered. [Staff #3] had [staff #4] step out of [client #1's] sight and worked with continuing behaviors until 10:05 PM when [client #1] fell asleep." Behaviors included client #1 going into client #2's room and running toward client #2 in bed. "A CPI escort was necessary to remove [client #1] from [client #2's] room. [Client #1] then pounded on [client #2's] door, turned			

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	the thermostat up to 99 degrees and then down to 22 degrees all in an attempt to bother [clients #2 and #3]. [Client #1] engaged in obsessive thought patterns about pulling the fire alarm. [Staff #3] redirected [client #1] each time. When [client #1] decided to pull [client #3] out of bed, [staff #3] blocked him and re-directed him to bed. [Client #1] finally laid down on his bed and asked [staff #3] for reassurance she was on his side. [Staff #3] answered that she was there to support him. [Staff #3] rubbed [client #1's] back for 20 minutes until [client #1] fell asleep." Corrective action indicated "Review actions of on call and supervisor [TM] to see if failed (sic) to provide support to [client #1] and staff. Add additional staff to Ridgeview roster. Review [client #1's] recent rash of behaviors." There was no evidence the allegation that client #1 made that staff #4 had choked him was investigated. A BDDS report dated 10/27/14 at 9:45 PM indicated "[client #1] got out of bed and asked where the overnight person was because he wanted to tease her. [Staff #2] worked with [client #1] to calm him down so he could go back to bed. [Client #1] insisted on staying up and was yelling inappropriate words trying to wake up other consumers. [Client #1] spoke with [relative] twice			

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	during the behavior. [Relative] tried assist (sic) with calming down and going to sleep. [Client #1] asked to talk to [QAD] after his second call to [relative]. [QAD] and [client #1] discussed fishing and things that make [client #1] happy. [Client #1] then got his ventriloquist dummy and started making inappropriate gestures and saying inappropriate things. [Client #1] calmed down and gave [staff #1] the dummy and his pirate hat in the office. [Staff #2] rubbed [client #1's] arms and hands upon [client #1's] request and as approved for calming [client #1] until [client #1] was ready for sleep." Corrective action indicated "IDT will convene to discuss the incident and develop a plan of action for [client #1's] continued aggression." There was no evidence of an IDT or of an investigation into the incident. There was no evidence in the BDDS reports provided that the incident detailed in the UIR dated 10/4/14 involving client #1 going to the neighbor's house, ringing their doorbell or of client #1 exposing himself to the neighbors, or of client #1's escort off neighbor's property was investigated. There was no evidence in the BDDS reports provided that the incident detailed in the UIR dated 10/5/14 in which client			

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	#1 went to the neighbor's house and rang their doorbells was investigated. There was no evidence in the BDDS reports provided that the incident detailed in the UIR dated 10/27/14 at 2:30 PM until 6:00 PM regarding client #1's behavior was reported to investigated, including client #1 "threatening to hit some of the other individuals" with a measuring spoon he used beat on the counter, and placing the spoon in the microwave to heat up. Client #1 asked if he could get a butter knife and hurt people with it, and client #1 made kissing noises at the neighbors, went to the neighbor's doors and "attempting to ring the doorbell and flip them off." Continuing Education Records were reviewed on 10/30/14 at 11:50 AM and included the following: 9/22/14: ".... TM talked about staffing; [Staff #4] wants to move to another location; uncomfortable working alone overnight...." 9/24/14; TM was trained on BDDS reporting; how to complete and what are reportable incidents. 9/29/14; indicated the TM, staff #4, staff #2, staff #6, staff #3 and the QAD were			

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	present for training on clients #1, #2 and #3's BSPs. 10/6/14; indicated the TM, staff #6, staff #2, staff #3 and staff #4 were trained regarding BSP competency evaluations for clients #1, #2 and #3. 10/13/14 indicated new goals for clients #1 and #2 were reviewed, and the schedule for the next two weeks was reviewed. 10/22/14 Team meeting notes indicated with staff #7, TM and NDQ present indicated "Staff is not to have drinks, coffee and soft drinks especially in the house of the customers. It was emphasized that this is the customer's home and we all know that some customers takes (sic) and either gulp them or give them to another customer. If this happens, staff needs to review their own behavior and how it affected the situation....On call pager: [NDQ] stated that the on call pager is assigned from Monday to Monday." 10/22/14; group home meeting indicated staff #1, #3, #5, and the TM were trained regarding medication administration. Minutes indicated the BS had provided training for client #2's goals, and use of a choice board.			

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	10/29/14 group home meeting minutes indicated staff #1, #2, #3, #5, the group home nurse, the NDQ and the BS were present at the meeting conducted by the QAD. The minutes indicated a review of goals for clients #1, #2, and #3, thoroughly completing progress notes, "Please keep drinks in your car!,...[client #1's] new behavioral PRN order-[nurse] working with (sic) the doctor to figure out a solution." Notes attached to the minutes indicated staff #3 would be working alone overnight from Monday through Thursday, all day on Saturday and Sunday and staff #4 would work overnight from 10:00 PM to 6:00 AM. There was no evidence of staff training regarding client #1's behavior plan and the use of CPI techniques, or of reporting abuse, neglect and mistreatment requirements. IDT meeting minutes dated 10/24/14 were reviewed on 10/30/14 at 5:10 PM and indicated "staff said they are comfortable with just a single staff. The only note was that if there were behaviors actively going on it would be helpful if a second overnight (sic) would be called in Per Required Need....The QAD suggests implementing a protocol where if one of the residents are actively exhibiting behaviors into the evening shift then one			

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	of the two evening shift staff would stay until midnight to make sure they are available for behavioral support. If behaviors are still occurring as it approaches midnight then staff will call in a second overnight (aka PRN overnight). CEO (Chief Executive Officer) and Direct Support Services agree that this plan is reasonable since the second overnight hasn't been needed so far and it still addresses future/potential behaviors." There was no indication in the meeting minutes reviewed of an investigation in regards to the incidents dated 10/5/14, 10/26/14 and 10/27/14 regarding client #1's behavior, or of the incident dated 10/16/14 regarding client #2's behavior. Investigations were reviewed on 10/30/14 at 5:10 PM. There was no indication in the investigations provided of corrective action/preventive steps in regards to the incidents dated 10/5/14, 10/26/14 and 10/27/14 regarding client #1's behavior, or of the incident dated 10/16/14 regarding client #2's behavior. The Quality Assurance Director (QAD) was interviewed on 10/31/14 at 11:47 AM. He indicated the incident dated 10/26/14 in which client #1 stated staff #5 had choked him was not investigated.			

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	He indicated the incidents of physically aggressive behavior between clients were not always formally investigated, but each incident went through a de-briefing process at the weekly team meetings to discuss proactive steps to take to prevent future occurrence. He indicated the NDQ was completing investigations into client #1's behavioral incidents on 10/26/14 and on 10/27/14. 9-3-2(a)			
W000155	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. Based upon record review and interview, the facility failed to failed to protect clients #1, #2 and #3 from further potential abuse during an investigation of alleged abuse involving client #1. Findings included: Unusual Incident Reports (UIRs) were	W000155	In order to correct the deficient practice and ensure it does not recur, all supervisory staff will be retrained on all policies/procedures related to incident reporting and investigations, including the importance of timely reporting, ensuring staff are suspended when abuse/neglect has been alleged, and thorough	12/03/2014

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	reviewed on 10/28/14 at 6:30 PM and included the following: An UIR signed on 10/23/14 completed by the TM (Team Manager) indicated on 10/20/14 at 4:30 PM client #1 saw neighbor kids and made "kissing noises and taunts...DSP (Direct Support Professional) tried verbal redirection." Writer (TM) intervened and prompted [client #1] to take a walk. [Client #1] complied. [Client #1] returned to home and continued making inappropriate comments/verbally aggressive. TM and DSP attempted verbal redirection, active ignoring, and proactive measures using careplan, but [client #1] continued. TM physically prompted [client #1] to take a walk by placing his hand on [client #1's] back. [Client #1] walked w/ (with) TM, but became agitated when a dog barked at him. When TM and [client #1] returned, TM prompted [client #1] to call his [relatives]. [Client #1] made verbal threats re: dog and others. TM directed [client #1] to take another walk, but [client #1] refused. [Client #1] dropped in the middle of the street and refused to walk. TM stood nearby as [client #1] made threats at neighbors who passed, yelling "F___you," and "Can I kill you?" Client #1 also pulled his pants down while in the street. The TM "physically prompted [client #1] to roll to his side		documentation of all resulting corrective action. The ND/Q will be in the home no less than twice weekly, in addition to weekly team meetings, in order to provide ongoing monitoring.Additionally, the DORS will be on-site no less than monthly, and the CEO will complete a quarterly on-site visit to review the overall setting and documentation. Additional ongoing monitoring will be completed by the Services Leadership team, who meet at least twice a month to review all BDDS reports and investigations.	

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	then stand and return to the house." Client #1 went to his room, then left his room, "and continued to be verbally aggressive, threatening staff/TM asking, "Can I kick you,"Can I spit on you," and "Can I bite you?" Client #1 was directed to use his emotions chart in his room, and "[client #1] followed TM and [staff #2] prompted client #1 to walk in the back yard. [Client #1] complied." When overnight staff #4 arrived to work in the home at 8:00 PM, she waited for client #1 to return to his room. Client #1 returned to his room, and staff #2 "stopped him from reaching [staff #4] (whom he was targeting)." Client #1 "continued to make threats, asking 'Can I pick on [staff #4]?'" TM "physically prompted [client #1] to continue his walk using [physical hold/escort technique]. [Client #1] walked w/ TM though he attempted to bite, kick, and spit on TM. When [client #1] finished his walk he went to his bed @ (at) 8:30 PM and remained there for the rest of the evening." An UIR dated 10/27/14 indicated "Duration of behavior; 1 hour, 45 minutes." Client #1 asked staff if he could get a butter knife and hurt people with it. Client #1 made kissing noises at the neighbor's house and "ruminated" regarding calling the cops and having CPI			

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	used on him. Client #1 beat on the counters with a metal spoon and "threatened to hit some of the other individuals with it." Client #1 "mentioned to [staff #2] that he was acting like this because he had anxiety about the TM's being here because he didn't want to be CPI escorted anymore." When the TM came to the group home, client #1 "started asking the TM if he was going to do CPI on him." Client #1 went to one of the neighbor's houses and "attempted to ring the door bell and flip them off." Client #1 asked if the neighbors would call the police, and was redirected off the neighbor's property. While walking from the neighbor's property client #1 "decided to go on another neighbor's property and attempt to ring their doorbell and upset them." The group home nurse, NDQ (Network Director/Qualified Intellectual Disabilities Professional), and staff #1 and #2 were able to redirect client #1 back to the group home and client #1 assisted staff #2 in making dinner. "When the TM came in with the other individuals, [client #1] started getting worked up again. He went into the living room where individual [client #3] was trying to watch a movie and started sticking that individual's exercise band in his mouth in an attempt to upset [client #3]. He was also mocking the [TM] a			

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	lot." Staff #2 redirected client #1 back to his room and talked to him about why he was getting himself worked up again after he had just calmed down. [Client #1] told [staff #1] that he still had anxiety about the [TM] and being CPI escorted....." The NDQ was interviewed on 10/28/14 at 5:05 PM. She indicated the Team Manager (TM) was no longer working in the group home. She stated the TM "had inappropriate behavior during an incident with [client #1], and left (employment) last night. It wasn't a good fit." She stated the TM was to leave on 10/31/14, "but left today instead." Staff #3 was interviewed on 10/29/14 at 6:50 AM. She indicated she had never seen the TM use inappropriate CPI, but stated "I did see him being more persistent than necessary in trying to get the guys to do stuff." The QAD (Quality Assurance Director) was interviewed on 10/29/14 at 12:30 PM. When asked about the investigation in regards to the TM using a CPI escorted walk with client #1, he indicated the Director of Support Services (DSS) had completed the investigation. He indicated the TM had worked in the group home under the supervision of administrative			

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	staff until the investigation had been completed. He stated the TM had not been using the CPI techniques with client #1 as a "last resort, but to gain compliance." He indicated the TM did not follow client #1's plan. The facility's reportable incidents to the BDDS since 9/26/14 were reviewed on 10/29/14 at 12:38 PM. A BDDS report dated 10/22/14 at 9:00 AM indicated client #1 "was outside with staff when he saw some girls from the neighborhood and began to make kissing noises. [Staff #2] asked [client #1] if this was an appropriate noise and [client #1] said no. He continued to make kissing noises. [TM] told [client #1] if he did not stop acting inappropriately [client #1] would be led on a walk. [Staff #2] went inside the home to assist other individuals. [TM] took [client #1] on a walk around the neighborhood. [Client #1] told [staff #2] it was a CPI (Crisis Prevention Institute) walk and this was confirmed by [TM]. Later [TM] took [client #1] on a few more CPI walks in the backyard of the home throughout the evening. [Staff #2] walked with [client #1] and he willingly held her hand while walking and talking to her. At no point was [client #1's] behavior aggressive." Corrective action indicated "an investigation into potential abuse is underway."			

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	An investigation initiated 10/23/14 indicated on 10/20/14, the TM took client #1 for a walk around the neighborhood. Client #1 told [staff #2] it was a "CPI walk," and this was confirmed by the TM. "Later the [TM] took [client #1] on a few more 'CPI' walks in the backyard of his home. [Staff #2] reported at no point was [client #1's] behavior aggressive. This report is being investigated as an allegation of violation of rights: failure to implement the behavior support plan and improper use of physical restraint." Statements indicated the QAD interviewed client #1 and client #1 "told [QAD] that they were raking leaves and he made kissing noises at the neighbor, so [TM] did CPI. [Client #1] said that made him feel angry, sad, scared and embarrassed. [Client #1] demonstrated on [QAD] how [TM] did a 'discipline walk,' by grabbing [QAD] with both arms and moving him. [Client #1] indicated there were lots of 'CPI' walks and he didn't like it...." The NDQ's statement indicated client #1 indicated to her the "CPI walks...happened no less than 5 times and he did not like CPI." The investigation indicated the unusual incident report indicated the date of the incident was 10/20/14, but the UIR (Unusual Incident Report) was 10/23/14. The QAD confirmed the date was in error and had			

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	occurred on 10/20/14. Progress notes reviewed in the investigation indicated client #1 had "NB's (not defined) from 4:30 -8:30 PM...Writer (TM) walked [client #1] each time he exhibited NB's'." (sic). Client #1's BSP was reviewed for the investigation and indicated "Reactive strategies for verbal aggression indicate that staff should only engage in conversation with [client #1] if he's talking about topics that are calming, and to return to proactive strategies when calm...Reactive strategies for physical aggression state that if [client #1] is physically aggressive and it escalates to a level where he or others appear to be in eminent (sic) danger, staff may need to use the appropriate physical intervention technique (CPI) for each unique situation in order to keep [client #1] and staff safe." The investigation indicated the allegation was "substantiated," and "Based on all the information available, including [TM's] documented account of the incident, it does appear [TM] violated [client #1's] rights by using a CPI hold when [client #1] was exhibiting verbal aggression, even though he was not a danger to himself or others." Recommendations indicated the behavior specialist "should provide additional training to staff to ensure all understand [client #1's] behavior support plan, and when it is appropriate to use physical			

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	intervention (only when [client #1] presents an eminent danger to himself or others." The investigation indicated it was completed on 10/27/14. The QAD was interviewed on 10/31/14 at 11:47 AM. He indicated the TM had continued to work in the group home after the incident where he used CPI escort as to gain compliance for client #1 on 10/20/14. He indicated the TM did not work alone, and was under the supervision of the NDQ. He stated, "In hindsight, he shouldn't have worked" until the investigation into the incident was completed. 9-3-2(a)			
W000157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.			

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	Based upon record review and interview, the facility failed to develop and implement effective corrective action to address the physically and verbally aggressive and sexually inappropriate behavior of client #1 and the physically aggressive behavior of client #2. Findings include: Unusual Incident Reports (UIRs) were reviewed on 10/28/14 at 6:30 PM and included the following reports: For client #1: An UIR dated 9/29/14 indicated client #1 got out of bed at 9:00 PM and stated that he "wanted to pick on [staff #4]." Client #1 "proceeded to make rude gestures and asked about Jubilee dessert (which had been the trigger of a previous behavior incident) and reached for his shorts." Client #1 was redirected from urinating on the floor. Staff #3 redirected client #1 to his room and redirected client #1 to breathing exercises and implemented rubbing client's #1 back with finger tips and discussed calming techniques for client #1 to use. An UIR dated 10/4/14 at 1:00 PM indicated client #1 was brought back	W000157	The Behavior Support Plans were revised for all young men living in the home only 2 months ago, and have undergone a number of revisions/enhancements, as a result of ongoing feedback from staff, based on their observations and experiences. At the same time the new BSPs were implemented,new activity schedules were introduces, involving the men in a wider variety of activities, and placing a higher level of expectations on them in regards to more community involvement, as well as expectations to increase independence at home. While it is true that interfering behaviors have not been completely eliminated, there has been a significant decrease in the frequency and severity of behaviors, and an increase in staff's ability and competence to respond in a consistent and appropriate manner. Staff will continue to meet at least twice per month, and will review all behavioral incidents and determine if strategies are effective, or if revisions to the BSPs are necessary. The Behavior Specialist continues to observe customers living in the home at least weekly,and is available by phone for consultation. She also trains each new staff on the BSPs to ensure competency. Ongoing monitoring will be accomplished through the Residential Services Monthly	12/03/2014

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	early from a visit with a relative to attend a Special Olympic bowling event. On the way to the event, client #1, "yelled wiener", calmed down, then went into the bowling alley to play video games. Once his money was gone, client #1 "flipped off" (profane gesture) staff from another group home. The incident report indicated during the incident client #1 hit and grabbed client #2, and upon returning home, "walked around the house kicking the house and banging on windows. When [client #1] saw that staff wasn't reacting to him beating on the house windows, he went to the neighbors house," rang their doorbell and attempted "to beat on" the neighbor's windows, but was redirected by staff. Client #1 "ruminated" about the police being called (no indication police were called in the report) and whether the neighbors would call police. Client #1 remained on their porch for an hour until the TM [Team Manager] on call arrived and escorted client #1 off the neighbor's property. Client #1 then tried to go to another neighbor's house, but was redirected, and continued to make "rude remarks and obscene gestures throughout the entire evening." After client #1 returned to the group home, he opened his bedroom window, "several times" pulled down his pants and "flipped off" the neighbors. Client #1 "eventually calmed down," then		Report, which provides a compilation of BDDS report information, as well as behavior data, and is disseminated to the IST for review. The ND/Q is in the home no less than twice per week to provide ongoing monitoring and support to staff, as well as to review all behavioral data. The DORS is in the setting no less than monthly, and the CEO will complete a quarterly on-site review.	

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	went on a van ride with clients #2 and #3 and 2 overnight staff. An UIR dated 10/5/14 (time not indicated) indicated while staff (unidentified) was preparing breakfast and staff #5 was preparing medications for administration, client #1 asked if staff #5 was going to "call the cops" or if neighbors would call the cops. Client #1 called the police from the group home office and when they arrived, client #1 "exposed his genitals" to police and tried to "grab" them as they left. The report indicated during the conversation between client #1 and police "that is was inappropriate to prank call police and next time it might not just be a talking to." Client #1 sat in the office with staff #5 and "ruminated on calling the police, going to Oktoberfest, getting neighbors to call the police." Client #1 "proceeded to try and exit residence stating that he was going to make them 'call the cops'." There was no indication client #1 left the group home during the incident. Client #2 went on an outing and client #3 went home while staff #5 stayed with client #1. An UIR signed on 10/23/14 completed by the TM indicated on 10/20/14 at 4:30 PM indicated "Duration of behavior, 4 hours." Client #1 saw neighbor kids and made "kissing noises and taunts...DSP			

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	(Direct Support Professional) tried verbal redirection." Writer (TM) intervened and prompted [client #1] to take a walk. [Client #1] complied. [Client #1] returned to home and continued making inappropriate comments/verbally aggressive. TM and DSP attempted verbal redirection, active ignoring, and proactive measures using careplan, but [client #1] continued. TM physically prompted [client #1] to take a walk by placing his hand on [client #1's] back. [Client #1] walked w/ (with) TM, but became agitated when a dog barked at him. When TM and [client #1] returned, TM prompted [client #1] to call his [relatives]. [Client #1] made verbal threats re: dog and others. TM directed [client #1] to take another walk, but [client #1] refused. [Client #1] dropped in the middle of the street and refused to walk. TM stood nearby as [client #1] made threats at neighbors who passed, yelling "F___you," and "Can I kill you?" Client #1 also pulled his pants down while in the street. The TM "physically prompted [client #1] to roll to his side then stand and return to the house." Client #1 went to his room, then left his room, "and continued to be verbally aggressive, threatening staff/TM asking, "Can I kick you,"Can I spit on you," and "Can I bite you?" Client #1 was directed to use his emotions chart in his room, and			

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	"[client #1] followed TM and [staff #2] prompted client #1 to walk in the back yard. [Client #1] complied." When overnight staff #4 arrived to work in the home at 8:00 PM, she waited for client #1 to return to his room. Client #1 returned to his room, and staff #2 "stopped him from reaching [staff #4] (whom he was targeting)." Client #1 "continued to make threats, asking 'Can I pick on [staff #4]?'" TM "physically prompted [client #1] to continue his walk using [physical hold/escort technique]. [Client #1] walked w/ TM though he attempted to bite, kick, and spit on TM. When [client #1] finished his walk he went to his bed @ (at) 8:30 PM and remained there for the rest of the evening." An UIR dated 10/26/14 from 8:25 PM-10:00 PM indicated "Duration of the behavior 1 hour, 54 minutes." Staff #3 left at 8:25 PM along with staff #1 as client #1 was lying down in his room "and all residents were quiet and in their bed (sic). On call [TM] had called staff back at 8:00 PM. Staff #1 talked to [TM] on phone then staff #1 informed me that TM told her that one of us had to stay until 10 PM (if there was an issue) even after [staff #1] made it clear that she couldn't ...and [staff #3's] car was being worked on so [staff #3] didn't have a way			

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	home. Staff #3 received a phone call from [TM] asking writer to come back because [staff #4] had called and asked [staff #5] to come in due to [client #1] coming out of his room and finding [staff #4] and (client #1) making the statement "You choked me, I'm going to call the cops. [Staff #5] claimed to have tried to reach [TM] by phone and pager but was unsuccessful. Staff did not successfully reach the on call [TM] after he called the house at 8:00 PM." Staff #3 arrived at the house at 8:34 PM, staff #4 stepped out of client #1's sight, and client #1 was directed into his room by staff #3. "Ten minutes later, [client #1] came out of room (sic), stating "Can I pick on [staff #4]?" [Client #1]...opened [client #2's] door and ran for [client #2's] bed. [Staff #3] used approved CPI escort to remove [client #1] from room and prevent [client #2] from coming to harm. Client #1 returned to his room and was asleep by 10:05 PM." An UIR dated 10/27/14 indicated "Duration of behavior; 1 hour, 45 minutes." Client #1 asked staff if he could get a butter knife and hurt people with it. Client #1 made kissing noises at the neighbor's house and "ruminated" regarding calling the cops and having CPI used on him. Client #1 beat on the counters with a metal spoon and			

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	"threatened to hit some of the other individuals with it." Client #1 "mentioned to [staff #2] that he was acting like this because he had anxiety about the TM's being here because he didn't want to be CPI escorted anymore." When the TM came to the group home, client #1 "started asking the TM if he was going to do CPI on him." Client #1 went to one of the neighbor's houses and "attempted to ring the door bell and flip them off." Client #1 asked if the neighbors would call the police, and was redirected off the neighbor's property. While walking from the neighbor's property client #1 "decided to go on another neighbor's property and attempt to ring their doorbell and upset them." The group home nurse, NDQ (Network Director/Qualified Intellectual Disabilities Professional), and staff #1 and #2 were able to redirect client #1 back to the group home and client #1 assisted staff #2 in making dinner. "When the TM came in with the other individuals, [client #1] started getting worked up again. He went into the living room where individual [client #3] was trying to watch a movie and started sticking that individual's exercise band in his mouth in an attempt to upset [client #3]. He was also mocking the [TM] a lot." Staff #2 redirected client #1 back to his room and talked to him about why he			

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	was getting himself worked up again after he had just calmed down. [Client #1] told [staff #1] that he still had anxiety about the [TM] and being CPI escorted....." An UIR dated 10/27/14 from 9:45 PM -11:30 PM indicated "Duration of behavior 1 hour and 45 minutes." Client #1 "got out of bed and asked where the overnight person was because he wanted to tease her." Staff #2 "went to help [client #1] calm down and go back to bed. [Client #1] insisted on staying up late and yelling inappropriate words trying to wake up the other consumers." Client #1 got his ventriloquist dummy and "started making inappropriate gestures and saying inappropriate things about the dummy." Client #1 called a relative twice and the QAD (Quality Assurance Director) and spoke about fishing before going back to bed. Staff #2 "rubbed [client #1's] arm and hand upon his request, and scratched his back until he was ready to go to sleep." For client #2: An UIR dated 10/4/14 MR at 4:00 PM indicated client #2 tried to drink from a beer tap behind the bar at a bowling alley before staff could intervene. Client #2			

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	attempted to drink from the tap and yelled "Just one beer" and left the bowling alley after Special Olympic staff told him and staff #3 the police would be called if his behavior did not stop. He exited the bowling alley before police were called. The report indicated client #2 was now banned from the bowling alley. There was no evidence of corrective action in the report. An UIR dated 10/16/14 indicated client #2 "stole" [staff #6's] drink, and client #2 lost a computer video opportunity "per his plan." Client #2 was "upset about losing a video," and "starting drawing his hand back as though to hit staff....[Client #2] grabbed [client #1] by arm (sic) and dug finger nails in.....[client #2] left welts on [client #1's] arm and scraped a small amount of skin. Marks and welts were still present over an hour later." There was no evidence of corrective action in the report. Staff #2 was interviewed on 10/28/14 at 5:08 PM. When asked about the incident with client #1 she stated, "We got through it." She stated the QAD was in the group home "occasionally." The QAD was interviewed on 10/28/14 at 5:25 PM. When asked about reportable incidents to the BDDS office, he			

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	indicated they would be available in the morning and stated, "There are a lot of them." Staff #3 was interviewed again on 10/29/14 at 6:50 AM. She indicated she had never seen the TM use inappropriate CPI, but stated "I did see him being more persistent than necessary in trying to get the guys to do stuff." She indicated client #2 also had an earning program for computer use and indicated if client #2 took something that was not his, he would lose an opportunity for using the computer. If he returns the item, he can re-earn the use of the computer. She indicated client #2 used laminated pictures of computers as a visual aid to earning the computer time to address stealing behavior. She indicated she was with client #2 at the bowling alley when he attempted to drink beer and stated, "I was right behind him." When asked about overnight staff, she stated, "They've discontinued 2 overnights (staff) since last Wednesday. They asked everyone if they felt comfortable. These guys once they're asleep, they're asleep. I was by myself last night." She indicated the overnight staff stayed until clients #2 and #3 left for the day. She indicated the clients usually were asleep by 8:00 PM and stated "By 10:00 PM everyone is asleep." She indicated the overnight staff			

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	worked from 8:00 or 10:00 PM until 8:00 AM. The QAD was interviewed on 10/29/14 at 12:30 PM. When asked about the investigation in regards to the TM using a CPI escorted walk with client #1, he indicated the Director of Support Services (DSS) had completed the investigation. He indicated the TM had worked in the group home under the supervision of administrative staff until the investigation had been completed. He stated the TM had not been using the CPI techniques with client #1 as a "last resort, but to gain compliance." He indicated the TM did not follow client #1's plan. The Behavior Specialist (BS) was interviewed on 10/29/14 at 12:40 PM and when asked how frequently she visited the home, she stated, "As behaviors are better, I'm available via phone. I come one time weekly and take phone calls from parents and staff. (I complete) random visits as part of our rotation (of monitoring)." The facility's reportable incidents to the BDDS since 9/26/14 were reviewed on 10/29/14 at 12:38 PM and included the following: 1. A BDDS report dated 9/26/14 at 4:10			

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	PM indicated client #1 was at the dinner table eating chicken when he made the statement "the bone looked like poop. He began obsessing over it...and began to target [client #2] and grabbed the back of his shirt...He began laughing loudly in [client #2's] ear. [Client #1] left the room then went after the roommate (client #3) again and scratched his neck. [Client #1] found a butter knife in the kitchen and said he was going to stab [client #2]. Staff removed the butter knife and took housemates to the back porch. Staff called the house manager for assistance. While waiting outside [client #1] pulled the fire alarm. Corrective action indicated a peer-to-peer investigation would be completed. A BDDS report dated 9/26/14 at 5:30 PM indicated client #1 "was in a drawn out behavior when he pulled the fire alarm. The alarm security company called the group home and staff acknowledged that there was no fire but emergency services came anyway. They toured (sic) the house to confirm there was no fire and left." Corrective action indicated "Staff will address the issue of [client #1] continuing to pull fire alarms at the staff meeting on Monday morning (9/26/14). The Team Manager (TM) and QAD (Quality Assurance Director) will make contact with the alarm company and			

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	confirm the protocol for calling off false alarms." A BDDS report dated 10/1/14 at 12:30 PM indicated client #1 started yelling "wiener" and "hysterically laughing...On arrival, one staff took the other two clients into the bowling alley to bowl while the other staff stayed in the van with [client #1] trying to calm him down." When he was calm, client #1 went into the bowling alley and played video games in the arcade. When client #1 ran out of money, he started "ruminating about Oktoberfest, how his toy he won looked like poop, and the word 'penis'." After calming down he recognized an individual from another group home and begin "flipping her off and yelling about how his toy looked like her poop." Staff helped the other two clients finish bowling then they all headed home. "On the way home, [client #1] grabbed and hit [client #2], then threw objects at him. Staff had [client #2] move to the back of the van away from [client #1] and while doing so [client #1] tried to poke [client #2] with a hula hoop." Corrective action indicated an "IDT meeting will convene today to discuss the incident and develop plan of action for [client #1's] continued aggression."			

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	A BDDS report dated 10/22/14 at 9:00 AM indicated client #1 "was outside with staff when he saw some girls from the neighborhood and began to make kissing noises. [Staff #2] asked [client #1] if this was an appropriate noise and [client #1] said no. He continued to make kissing noises. [TM] told [client #1] if he did not stop acting inappropriately [client #1] would be led on a walk. [Staff #2] went inside the home to assist other individuals. [TM] took [client #1] on a walk around the neighborhood. [Client #1] told [staff #2] it was a CPI (Crisis Prevention Institute) walk and this was confirmed by [TM]. Later [TM] took [client #1] on a few more CPI walks in the backyard of the home throughout the evening. [Staff #2] walked with [client #1] and he willingly held her hand while walking and talking to her. At no point was [client #1's] behavior aggressive." Corrective action indicated "an investigation into potential abuse is underway." A BDDS report dated 10/26/14 at 8:25 PM and reported on 10/28/14 indicated client #1 came out of his room after going to bed and told [staff #4] "You choked me. I am going to call the cops." [Staff #3] returned the (sic) when [staff #4] called her to assist. Calls by [staff #1], [staff #4] and [staff #3] to on call			

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	and cell of [TM] went unanswered. [Staff #3] had [staff #4] step out of [client #1's] sight and worked with continuing behaviors until 10:05 PM when [client #1] fell asleep." Behaviors included client #1 going into client #2's room and running toward client #2 in bed. "A CPI escort was necessary to remove [client #1] from [client #2's] room. [Client #1] then pounded on [client #2's] door, turned the thermostat up to 99 degrees and then down to 22 degrees all in an attempt to bother [clients #2 and #3]. [Client #1] engaged in obsessive thought patterns about pulling the fire alarm. [Staff #3] redirected [client #1] each time. When [client #1] decided to pull [client #3] out of bed, [staff #3] blocked him and re-directed him to bed. [Client #1] finally laid down on his bed and asked [staff #3] for reassurance she was on his side. [Staff #3] answered that she was there to support him. [Staff #3] rubbed [client #1's] back for 20 minutes until [client #1] fell asleep." Corrective action indicated "Review actions of on call and supervisor [TM] to see if failed (sic) to provide support to [client #1] and staff. Add additional staff to Ridgeview roster. Review [client #1's] recent rash of behaviors." A BDDS report dated 10/27/14 at 9:45 PM indicated "[client #1] got out of bed			

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	and asked where the overnight person was because he wanted to tease her. [Staff #2] worked with [client #1] to calm him down so he could go back to bed. [Client #1] insisted on staying up and was yelling inappropriate words trying to wake up other consumers. [Client #1] spoke with [relative] twice during the behavior. [Relative] tried assist (sic) with calming down and going to sleep. [Client #1] asked to talk to [QAD] after his second call to [relative]. [QAD] and [client #1] discussed fishing and things that make [client #1] happy. [Client #1] then got his ventriloquist dummy and started making inappropriate gestures and saying inappropriate things. [Client #1] calmed down and gave [staff #1] the dummy and his pirate hat in the office. [Staff #2] rubbed [client #1's] arms and hands upon [client #1's] request and as approved for calming [client #1] until [client #1] was ready for sleep." Corrective action indicated "IDT will convene to discuss the incident and develop a plan of action for [client #1's] continued aggression." Client #1's BSP dated September, 2014 was reviewed on 10/28/14 at 6:04 PM. Targeted behaviors included Enuresis/Encopresis (urinating and bowel movements intentionally occurring when not in the bathroom), calling 911,			

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	physical aggression (hitting, spitting, touching staff in private areas, throwing objects at others), verbal aggression (name calling, making threats towards others, asking others if he can cause harm to them). The plan indicated "Reactive strategies for verbal aggression indicate that staff should only engage in conversation with [client #1] if he's talking about topics that are calming, and to return to proactive strategies when calm...Reactive strategies for physical aggression state that if [client #1] is physically aggressive and it escalates to a level where he or others appear to be in imminent danger, staff may need to use the appropriate physical intervention technique (CPI) for each unique situation in order to keep [client #1] and staff safe." There was no indication of which CPI techniques to use or hierarchy for their use. The BSP did not include physical interventions as a reactive strategy for verbal aggression. For client #2: A BDDS report dated 10/4/14 at 1:00 PM indicated client #2 "tried to force" client #3 to drink lemonade. Staff #3 intervened, but client #2 "tried to choke her and hit her in the back." The report indicated "Writer" (unidentified) used an interim position hold to remove [client			

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	#2] from the area and walk him to his room. [Client #2] threw blankets at writer until writer kept them all. Writer told [client #2] that if he continued to "try to hit" he would not watch his videos on the computer. [Client #2] took a VHS tape from his closet and raised it to strike writer. Writer told [client #2] if he hit him he would lose all his tapes. [Client #2] put his VHS back and said B-A-M-B-I.' Writer replied 'If you want to watch Bambi as one of your videos you need to put all the blankets back on your bed and write your list.' [Client #2] complied. Writer noted a small finger/thumb print on the right side of [staff #3's] neck...This behavior lasted approximately 10 min (minutes)." Corrective action indicated "Review BSP and adjust actions accordingly." A BDDS report dated 10/4/14 at 2:30 PM indicated client #2 went bowling in another city. "Right before it was time to leave the bowling alley [client #2] walked over to the bar at the alley with staff right behind him. [Client #2] grabbed a cup and tried to pour himself a beer from the tap. Staff dumped it out and [client #2] continued to try and get more cups. Staff attempted to redirect [client #2] but [client #2] kept saying 'one beer'." Staff said 'no beer' and [client #2] attempted to drink out of the tap itself.			

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	[Client #2] had a strong grip on it and was spilling beer on the floor. The second staff arrived at this point and got [client #2] out from behind the bar. [Client #2] then fell to the floor and began yelling and banging his hands on the floor. A Special Olympics staff then told Ridgeview staff and [client #2] that if this continued they would have to call the police. After repeating this to [client #2] a couple of times he stopped and then calmed down and left with staff." Corrective action indicated "Emergency IDT will convene today to discuss the incident and determine measures to address the incident." A BDDS dated 10/18/14 indicated client #2 "opened the office and drank writer's (unidentified) coffee...One staff took one of [client #2's] videos off of his picture chart. Staff explained why he lost the video-for stealing." Client #2 began to "get upset and began to yell that he wanted 'F-I-V-E'!" Client #2 "dug his nails" into writer's arm, then took a quarter and began hitting the writer in the arm with the quarter. Client #2 grabbed the arm of unidentified staff and threw change, hitting writer. Writer collected the money and gave it to staff. This caused client #2 "to begin yelling about money." Client #2 was given the money when he calmed down. Corrective action			

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	indicated "Continue to document negative behaviors and follow BSP. A BDDS report dated 10/26/14 indicated client #2 "has been taking food from glass containers and dumping them out in order to recycle. [Client #2] was asked not to dump the food and he lost a video off of his chart. [Client #2] was upset and crying about losing the video. [Client #2] grabbed writer's (unidentified) arm and [staff #3's] arm and left a mark. [Client #2] then proceeded to open and close the patio door, slamming the door hard enough to break the key off in the door." Corrective action indicated "Continue to follow BSP." Client #2's record was reviewed on 10/29/14 at 8:46 AM. A BSP dated 9/14/14 included target behaviors of physical display of frustration (screaming, crying, jumping up and down and yelling 'no'), physical aggression (kicking, slapping, pinching, hitting with objects), PICA (ingesting non-edible items such as paper, grass, dog food, raw meat, pen caps, hair bands, pencil erasers, etc), taking food/drinks (taking food or drinks from others or any food/drink sitting out), public masturbation (touching genital area when in public or around others). The interventions for the targeted behaviors did not include the			

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	removal of videos or of watching videos on the computer. 3. A BDDS dated 9/26/14 indicated client #3 was "very agitated when he woke up in the morning around 5:45 AM. He has a history of 'cycling' where he becomes increasingly agitated and it leads to outbursts of aggression. The previous day the Human Rights Committee had approved a prescribed PRN (as needed) for just such instances. Staff tried all the proactive measures written in his protocol to try and calm him down. They did not succeed and as he became increasingly agitated the [Team Manager] called [LPN] (licensed practical nurse)], and agency nurse, at 6:30 AM and described the situation. She recommended the use of the PRN Ativan. It was administered per protocol and [client #3] was monitored and encouraged to relax. He lay on the couch and watch a favorite movie. Staff said he seem (sic) to calm down a bit but still showed signs of agitation." Corrective action indicated the team manager will continue to monitor and follow protocol as written and provide feedback to the director of quality assurance and the LPN. A BDDS report dated 9/26/14 at 12:30 PM indicated client #3 required an			

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	additional PRN medication as he "continued to become more agitated as the day progressed, pacing and rubbing his hands together in the way that commonly precedes such acts of aggression..." Corrective action indicated client #3's response to the PRN medication would be monitored. A BDDS report dated 9/26/14 at 7:18 PM indicated client #3 was looking at videos on his electronic tablet and client #2 came into the room and attempted to take it from him. Client #3 then "gravved (sic) [client #2] and left a red ring around his neck and ripped his shirt fighting him to get his ipad back. When staff (unidentified) went to separate the two [client #3] grabbed her (staff) and removed her shirt and bra as well." The report indicated the house manager restrained client #3 and held him on the ground for a minute until he was calm. Corrective action indicated a peer to peer investigation would be completed. Client #3's BSP dated September, 2014 was reviewed on 10/29/14 at 8:40 AM. Targeted behaviors indicated physical aggression (pulling shirt off of others), self injurious behavior (rubbing fingers together until they are raw), elopement (climbing out of windows, running away from staff). The plan included the use of			

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	Vistaril 25 mg (milligrams) as needed for insomnia and Ativan .5 mg one tablet by mouth every 6 hours as needed for agitation. The plan indicated for physical aggression "if [client #3] continues to be physically aggressive and it escalates to a level where he or others appear to be in imminent danger, staff may need to use the appropriate physical intervention technique (CPI) for each unique situation in order to keep [client #3] and the staff safe." Staff #3 and staff #1 were interviewed on 10/29/14 at 8:30 AM. When asked about the incident dated 10/26/14 in which staff #3 she was called back to work after leaving for the night, staff #3 stated, "Everything was quiet when we left," and client #1 "was on his way to sleep." Staff #3 stated, "He's been known to get up after being asleep for an hour." Staff #1 indicated she took staff #1 to her car and staff #3 indicated staff #4 was alone with client #1 "a half hour or less." Staff #1 and #3 indicated they were unable to reach the TM who was on call to address the staffing needs of the home. Continuing Education Records were reviewed on 10/30/14 at 11:50 AM and included the following: 9/22/14: ".... TM talked about staffing;			

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	[Staff #4] wants to move to another location; uncomfortable working alone overnight...." 9/24/14; TM was trained on BDDS reporting; how to complete and what are reportable incidents. 9/29/14; indicated the TM, staff #4, staff #2, staff #6, staff #3 and the QAD were present for training on clients #1, #2 and #3's BSPs. 10/6/14; indicated the TM, staff #6, staff #2, staff #3 and staff #4 were trained regarding BSP competency evaluations for clients #1, #2 and #3. 10/13/14 indicated new goals for clients #1 and #2 were reviewed, and the schedule for the next two weeks was reviewed. 10/22/14 Team meeting notes indicated with staff #7, TM and NDQ present indicated "Staff is not to have drinks, coffee and soft drinks especially in the house of the customers. It was emphasized that this is the customer's home and we all know that some customers takes (sic) and either gulp them or give them to another customer. If this happens, staff needs to review their own behavior and how it affected the			

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	situation....On call pager: [NDQ] stated that the on call pager is assigned from Monday to Monday." 10/22/14; group home meeting indicated staff #1, #3, #5, and the TM were trained regarding medication administration. Minutes indicated the BS had provided training for client #2's goals, and use of a choice board. 10/29/14 group home meeting minutes indicated staff #1, #2, #3, #5, the group home nurse, the NDQ and the BS were present at the meeting conducted by the QAD. The minutes indicated a review of goals for clients #1, #2, and #3, thoroughly completing progress notes, "Please keep drinks in your car!,...[client #1's] new behavioral PRN order-[nurse] working with (sic) the doctor to figure out a solution." Notes attached to the minutes indicated staff #3 would be working alone overnight from Monday through Thursday, all day on Saturday and Sunday and staff #4 would work overnight from 10:00 PM to 6:00 AM. There was no evidence of staff training regarding client #1's behavior plan and the use of CPI techniques, or of reporting abuse, neglect and mistreatment requirements. IDT meeting minutes dated 10/5/14			

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	regarding the 10/4/14 incidents involving clients #1 and #2 on 10/4/14 were reviewed on 10/28/14 at 5:45 PM and indicated the following recommendations: 1. "Behavior specialist (BS) following up with [client #1's] psychiatrist about a behavioral PRN (as needed medication)." 2. "Adjust [client #1's] earning program to lengthen or change the period of earning." 3. "Speak with [clients #3 and #1's] families about scheduling visits further in advance." 4. "Consider writing drink seeking component to [client #2's] behavior plan." 5. "Reminding staff that rubbing [client #1's] back helps in calming him down." 6. "Have [staff #7] stay today until [client #1] wakes up to help with potential behaviors." 7. "Have someone (BS, staff #7, or Quality Assurance Direct or (QAD) follow up with the neighbors." 8. "[QAD] is available as backup staff for this evening if behaviors continue." Emergency IDT meeting minutes for the 9/26/14 incident were reviewed on 10/30/14 and indicated the following: For client #1:			

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	-"Reminding all visitors to moving to the office (sic) and shutting the door during behaviors" -"Re-directing [client #1] either to his room, a car ride, or a walk" -"Moving other customers and staff away from the immediate vicinity" -"Build potential loss of extra activities into earning program for negative behavior" For client #2: -"Getting [client #2] his own computer-set up in living room, set times of day, make a goal" -"Encourage writing instead of printing" For client #3 -"Ativan PRN seemed to help during the day" -"Encouraging [client #3] to use his ipad in his room (not restricting, just encouraging him) -Assuring staff are in the living room with the guys whenever more than one is in there" IDT meeting minutes dated 10/24/14 were reviewed on 10/30/14 at 5:10 PM and indicated "staff said they are comfortable with just a single staff. The only note was that if there were behaviors actively going on it would be helpful if a			

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	second overnight (sic) would be called in Per Required Need....The QAD suggests implementing a protocol where if one of the residents are actively exhibiting behaviors into the evening shift then one of the two evening shift staff would stay until midnight to make sure they are available for behavioral support. If behaviors are still occurring as it approaches midnight then staff will call in a second overnight (aka PRN overnight). CEO (Chief Executive Officer) and Direct Support Services agree that this plan is reasonable since the second overnight hasn't been needed so far and it still addresses future/potential behaviors." There was no indication in the meeting minutes of an investigation or corrective action/preventive steps in regards to the incidents dated 10/5/14, 10/26/14 and 10/27/14 regarding client #1's behavior, or of the incident dated 10/16/14 regarding client #2's behavior. Investigations were reviewed on 10/30/14 at 5:10 PM and indicated the following: An investigation dated 9/29/14 into the incident dated 9/26/14 indicated client #1 scratched client #2's neck and pulled his shirt, and pulled the fire alarm. Recommendations indicated "Group			

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	home staff and IDT should meet to de-brief the situation and discuss the effectiveness of the behavior plan, as well as both proactive and reactive techniques that could have helped the situation. The agency's Behavior Specialist should be consulted to determine if changes to the plan need to be made. Findings should be forwarded to the CEO, DoSS (Director of Support Services) and QAD for review." An investigation dated 10/5/14 and completed 10/5/14 indicated client #1 had been "upset at the bowling alley and chose not to bowl. He had been upset about coming home early from a visit with his mother. At the alley he began to ruminate about 'Oktoberfest,' how his toy looked like poop, and the word 'penis'. On the drive home, [client #1] grabbed [client #2's] shirt and threw undefined 'objects' at him. Staff had [client #2] move to the back of the van and sat between them, but [client #1] used a hula hoop to try and poke [client #2]." Recommendations indicated "The behaviors are addressed in [client #1's] behavior plan, but the incidents from the day should be discussed with an IDT de-briefing to occur within two days. Any further findings and recommendations should be forwarded to the DSS (Director of Support Services) and CEO."			

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	An investigation initiated 10/23/14 indicated on 10/20/14, the TM took client #1 for a walk around the neighborhood. Client #1 told [staff #2] it was a "CPI walk," and this was confirmed by the TM. "Later the [TM] took [client #1] on a few more 'CPI' walks in the backyard of his home. [Staff #2] reported at no point was [client #1's] behavior aggressive. This report is being investigated as an allegation of violation of rights: failure to implement the behavior support plan and improper use of physical restraint." Statements indicated the QAD interviewed client #1 and client #1 "told [QAD] that they were raking leaves and he made kissing noises at the neighbor, so [TM] did CPI. [Client #1] said that made him feel angry, sad, scared and embarrassed. [Client #1] demonstrated on [QAD] how [TM] did a 'discipline walk,' by grabbing [QAD] with both arms and moving him. [Client #1] indicated there were lots of 'CPI' walks and he didn't like it...." The NDQ's statement indicated client #1 indicated to her the "CPI walks...happened no less than 5 times and he did not like CPI." The investigation indicated the unusual incident report indicated the date of the incident was 10/20/14, but the UIR (Unusual Incident Report) was 10/23/14. The QAD confirmed the date was in error and had occurred on 10/20/14. Progress notes			

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	reviewed in the investigation indicated client #1 had "NB's (not identified) from 4:30 -8:30 PM...Writer (TM) walked [client #1] each time he exhibited NB's'." (sic). Client #1's BSP was reviewed for the investigation and indicated "Reactive strategies for verbal aggression indicate that staff should only engage in conversation with [client #1] if he's talking about topics that are calming, and to return to proactive strategies when calm...Reactive strategies for physical aggression state that if [client #1] is physically aggressive and it escalates to a level where he or others appear to be in eminent (sic) danger, staff may need to use the appropriate physical intervention technique (CPI) for each unique situation in order to keep [client #1] and staff safe." The investigation indicated the allegation was "substantiated," and "Based on all the information available, including [TM's] documented account of the incident, it does appear [TM] violated [client #1's] rights by using a CPI hold when [client #1] was exhibiting verbal aggression, even though he was not a danger to himself or others." Recommendations indicated the behavior specialist "should provide additional training to staff to ensure all understand [client #1's] behavior support plan, and when it is appropriate to use physical intervention (only when [client #1]			

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	presents an eminent danger to himself or others." The investigation indicated it was completed on 10/27/14. There was no indication in the investigations provided of corrective action/preventive steps in regards to the incidents dated 10/5/14, 10/26/14 and 10/27/14 regarding client #1's behavior, or of the incident dated 10/16/14 regarding client #2's behavior. The Quality Assurance Director (QAD) was interviewed on 10/31/14 at 11:47 AM. He indicated the incident dated 10/20/14 had not been reported timely, and indicated the TM had continued to work in the group home after the incident where he used CPI escort as to gain compliance for client #1 on 10/20/14. He indicated the TM did not work alone, and was under the supervision of the NDQ. He stated, "In hindsight, he shouldn't have worked" until the investigation into the incident was completed. He indicated he was aware of the incidents on 10/4/14 and on 10/5/14 in which client #1 called police, attempted to grab police officers, exposed himself to police and neighbors, and rang neighbors doorbells. He indicated they had not been reported to BDDS as the NDQ was new to the position and still learning how to file reports. He indicated the incident dated			

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	10/26/14 in which client #1 stated staff #5 had choked him was not investigated. He indicated staff had been trained on reporting requirements after each incident during weekly group home meetings, but the training was verbal and not documented. He indicated the incident dated 10/1/14 regarding client #1's behavior at the bowling alley was in error and the incident occurred on 10/4/14. He indicated the incidents of physically aggressive behavior between clients were not always formally investigated, but each incident went through a de-briefing process at the weekly team meetings to discuss proactive steps to take to prevent future occurrence. He indicated the group home staff were now working closely with client #3's school to prevent re-occurrence of client #3's physically aggressive behavior, but had not yet implemented an intervention to address client #3's property destruction. He indicated while client behaviors had improved since the last survey, the facility still was in process of completing corrective action to address client behaviors. The DoSS (Director of Support Services) was interviewed on 11/3/14 at 4:50 PM and stated she was uncertain as to the definition of "NB" as indicated in the TM's documentation of the incident on			

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	10/20/14. This deficiency was cited on September 12, 2014. The facility failed to implement a systemic plan of correction to prevent reoccurrence. 9-3-2(a)			
W000159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based upon record review and interview, the facility failed for 2 of 2 sampled clients (clients #1 and #2) to ensure the QIDP (Qualified Intellectual Disabilities Professional) completed periodic reviews of their ISP (Individual Support Plan) objectives and failed to ensure staff were	W000159	To correct the deficient practice and ensure it does not continue, the ND/Q has been trained by the Behavior Specialist on all individual's BSPs. The ND/Q will be re-trained on the Residential Services Monthly Report, which includes a review of progress on the ISP objectives. She will also	12/03/2014

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	trained to implement client plans. Findings include: 1. Client #1's record was reviewed on 10/28/14 at 6:04 PM. A BSP (Behavior Support Plan) dated 9/14 included targeted behaviors of Enuresis/Encopresis (urinating and bowel movements intentionally occurring when not in the bathroom), calling 911, physical aggression (hitting, spitting, touching staff in private areas, throwing objects at others), verbal aggression (name calling, making threats towards others, asking others if he can cause harm to them). The plan indicated "Reactive strategies for verbal aggression indicate that staff should only engage in conversation with [client #1] if he's talking about topics that are calming, and to return to proactive strategies when calm...Reactive strategies for physical aggression state that if [client #1] is physically aggressive and it escalates to a level where he or others appear to be in imminent danger, staff may need to use the appropriate physical intervention technique (CPI) for each unique situation in order to keep [client #1] and staff safe." An ISP dated 9/26/14 indicated objectives to complete a personal hygiene checklist daily, assist in meal preparation, call relative, complete activity with peers		be re-trained on the LifeDesigns annual process. The ND/Q will complete Residential Services Monthly Reports for each individual living in the home, and will forward to the DORS and CEO for review, as well as the IST. Ongoing monitoring will be accomplished through a system developed by the Services Administrative Assistant, who will remind ND/Qs monthly of the approaching deadline to submit the Monthly Reports, and will track receipt of all Monthly Reports, including the DORS, DOSS and CEO on all related communication.	

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	once weekly, complete a financial transaction, chew food thoroughly and sit up at the table, pop out medications from the bubble pack, and use soap and washcloth during bathing. There was no evidence of a QIDP (Qualified Intellectual Disabilities Professional) review of client #1's progress in his ISP or BSP. 2. Client #2's record was reviewed on 10/29/14 at 8:46 AM. A BSP dated 9/14/14 included target behaviors of physical display of frustration (screaming, crying, jumping up and down and yelling 'no'), physical aggression (kicking, slapping, pinching, hitting with objects), PICA (ingesting non-edible items such as paper, grass, dog food, raw meat, pen caps, hair bands, pencil erasers, etc), taking food/drinks (taking food or drinks from others or any food/drink sitting out), public masturbation (touching genital area when in public or around others). The interventions for the targeted behaviors did not include the removal of videos or of watching videos on the computer. Client #2's ISP dated 9/26/14 indicated objectives to count change, stay within eyesight of staff during community outings, say name of medication he is taking, use soap and water to thoroughly wash himself, prepare a healthy snack, use a			

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	communication board to express wants and needs, stay engaged using "first___, then___" strategy. There was no evidence of a QIDP (Qualified Intellectual Disabilities Professional) review of client #2's progress in his ISP or BSP. The Quality Assurance Director was interviewed on 10/31/14 at 11:47 AM and indicated the reviews of clients #1 and #2's plans had not been completed by the QIDP. 3. The QIDP failed to ensure staff demonstrated competency to implement 2 of 2 sampled clients' (clients #1 and #2's) plans to address maladaptive behavior. Please see W191. This deficiency was cited on September 12, 2014. The facility failed to implement a systemic plan of correction to prevent reoccurrence. 9-3-3(a)			

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W000164	483.430(b)(1) PROFESSIONAL PROGRAM SERVICES Each client must receive the professional program services needed to implement the active treatment program defined by each client's individual program plan. Based on observation, record review and interview for 2 of 2 sampled clients (clients #1 and #2), and for 1 additional client (client #3), the facility failed to assure the professional program services clinician (behavioral specialist) was available to provide training on the clients' behavior support plans (BSPs). Findings include: Observations were completed at the group home on 10/29/14 from 6:50 AM until 8:55 AM. Staff #1 worked in the home with clients #1, #2 and #3 as they prepared breakfast and took medications. Staff #1 was interviewed on 10/29/14 at 7:15 AM and indicated she had not received training from the Behavior Specialist (BS) regarding client #1, #2's behavior plans and stated, "I've only met her once." She indicated she had worked	W000164	To correct the deficient practice, the Behavior Specialist has trained all staff working in the home on the BSPs. To ensure the deficient practice does not continue, the LifeDesigns Customer Specific Orientation Record (CSOR) will be revised to clearly indicate that training related to a Behavior Support Plan must be completed by the applicable Behavior Specialist.The CSOR must be completed and signed by the ND/Q and DORS, then submitted to the Employee Development Coordinator, prior to a new staff being added to the work schedule in the setting. Ongoing monitoring will be accomplished through the Behavior Specialist regular presence in the group home (at least weekly),and participation in team meetings.	12/03/2014

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	in the group home for 2 or 3 weeks. Observations were completed at the group home on 10/29/14 from 12:38 PM until 2:30 PM. The QIDP (Qualified Intellectual Disabilities Professional) and staff #1 sat with the BS reviewing clients #1 and #2's behavior plans. Client #1's record was reviewed on 10/28/14 at 6:04 PM. A BSP dated 9/14 included targeted behaviors of Enuresis/Encopresis (urinating and bowel movements intentionally occurring when not in the bathroom), calling 911, physical aggression (hitting, spitting, touching staff in private areas, throwing objects at others), verbal aggression (name calling, making threats towards others, asking others if he can cause harm to them). The plan indicated "Reactive strategies for verbal aggression indicate that staff should only engage in conversation with [client #1] if he's talking about topics that are calming, and to return to proactive strategies when calm...Reactive strategies for physical aggression state that if [client #1] is physically aggressive and it escalates to a level where he or others appear to be in imminent danger, staff may need to use the appropriate physical intervention technique (CPI) for each unique situation in order to keep [client #1] and staff			

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	safe." Client #2's record was reviewed on 10/29/14 at 8:46 AM. A BSP dated 9/14/14 included target behaviors of physical display of frustration (screaming, crying, jumping up and down and yelling 'no'), physical aggression (kicking, slapping, pinching, hitting with objects), PICA (ingesting non-edible items such as paper, grass, dog food, raw meat, pen caps, hair bands, pencil erasers, etc), taking food/drinks (taking food or drinks from others or any food/drink sitting out), public masturbation (touching genital area when in public or around others). The interventions for the targeted behaviors did not include the removal of videos or of watching videos on the computer. Staff training records were reviewed on 10/30/14 at 11:50 AM and failed to indicate staff #1 and the QIDP were trained by the Behavior Specialist on client plans. Behavior Support Competency Evaluations were reviewed on 10/30/14 at 12:03 PM and failed to indicate staff #1 and the QIDP were trained to competency on client behavior plans. The QAD (Quality Assurance Director)			

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	was interviewed on 10/29/14 at 12:25 PM and indicated the BS was completing training with the QIDP and staff #1 as they were not present at the meeting where the previous training on client BSPs had been conducted. The BS was interviewed on 10/29/14 at 12:40 PM and when asked how frequently she visited the home, she stated, "As behaviors are better, I'm available via phone. I come one time weekly and take phone calls from parents and staff. (I complete) random visits as part of our rotation (of monitoring)." This deficiency was cited on September 12, 2014. The facility failed to implement a systemic plan of correction to prevent reoccurrence. 9-3-3(a)			
W000186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.			

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	Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on record review and interview for 2 of 2 sampled clients (clients #1 and #2) and for 1 additional client (client #3), the facility failed to ensure there were adequate staff to meet the clients' behavioral/programming needs. Findings include: A staff list provided upon entrance to the survey on 10/28/14 at 5:30 PM indicated one staff was scheduled to work in the group home from 10:00 PM until 8:00 AM daily. Unusual Incident Reports (UIRs) were reviewed on 10/28/14 at 6:30 PM and included the following reports: An UIR dated 9/29/14 indicated client #1 got out of bed at 9:00 PM and stated that he "wanted to pick on [staff #4]." Client #1 "proceeded to make rude gestures and asked about Jubilee dessert (which had been the trigger of a previous behavior incident) and reached for his shorts." Client #1 was redirected from urinating on the floor. Staff #3 redirected client #1 to his room and redirected client #1 to breathing exercises and implemented rubbing client's #1 back with finger tips and discussed calming techniques for	W000186	To correct the deficient practice, client #1 (the individual who exhibited incidents of getting up after he had gone to bed), is in the process of moving out of the home and pursuing Supported Living funded by the Medicaid Waiver. An emergency plan is in place, and has been effective during the cited incidents when he did get out of bed and staff needed assistance. Staffing needs will continue to be reviewed at each Team Meeting. Ongoing monitoring will be accomplished by a review of all BDDS reports by the Services Leadership Team, which meets at least twice monthly. Additionally, all ND/Qs review staffing needs/ concerns with the DORS when they meet at least twice monthly.	12/03/2014

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	client #1 to use. An UIR dated 10/26/14 from 8:25 PM-10:00 PM indicated "Duration of the behavior 1 hour, 54 minutes." Staff #3 left at 8:25 PM along with staff #1 as client #1 was lying down in his room "and all residents were quiet and in their bed (sic). On call [TM (Team Manager)] had called staff back at 8:00 PM. Staff #1 talked to [TM] on phone then staff #1 informed me that TM told her that one of us had to stay until 10 PM (if there was an issue) even after [staff #1] made it clear that she couldn't ...and [staff #3's] car was being worked on so [staff #3] didn't have a way home. Staff #3 received a phone call from [TM] asking writer to come back because [staff #4] had called and asked [staff #5] to come in due to [client #1] coming out of his room and finding [staff #4] and (client #1) making the statement "You choked me, I'm going to call the cops. [Staff #5] claimed to have tried to reach [TM] by phone and pager but was unsuccessful. Staff did not successfully reach the on call [TM] after he called the house at 8:00 PM." Staff #3 arrived at the house at 8:34 PM, staff #4 stepped out of client #1's sight, and client #1 was directed into his room by staff #3. "Ten minutes later, [client #1] came out of room (sic), stating "Can I pick on [staff #4]?" [Client #1]...opened			

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	[client #2's] door and ran for [client #2's] bed. [Staff #3] used approved CPI (Crisis Prevention Institute) escort to remove [client #1] from room and prevent [client #2] from coming to harm. Client #1 returned to his room and was asleep by 10:05 PM." Staff #3 was interviewed on 10/29/14 at 6:50 PM. She indicated the decision had been made last Wednesday (10/22) to staff the overnight shift with only one staff, but that 2nd shift staff who are scheduled to leave at 10:00 PM will need to ensure clients are asleep before leaving. She indicated all staff indicated at the meeting they were comfortable with working alone from 10 PM-6 AM and clients typically stay asleep for the night after going asleep. Staff #3 and staff #1 were interviewed on 10/29/14 at 8:30 AM. When asked about the incident dated 10/26/14 in which staff #3 she was called back to work after leaving for the night, staff #3 stated, "Everything was quiet when we left," and client #1 "was on his way to sleep." Staff #3 stated, "He's been known to get up after being asleep for an hour." Staff #1 indicated she took staff #3 to her car and staff #3 indicated staff #4 was alone with client #1 "a half hour or less." Staff #1 and #3 indicated they were unable to			

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	reach the TM who was on call to address the staffing needs of the home. IDT meeting minutes dated 10/24/14 were reviewed on 10/30/14 at 5:10 PM and indicated "staff said they are comfortable with just a single staff. The only note was that if there were behaviors actively going on it would be helpful if a second overnight (sic) would be called in Per Required Need....The QAD suggests implementing a protocol where if one of the residents are actively exhibiting behaviors into the evening shift then one of the two evening shift staff would staff until midnight to make sure they are available for behavioral support. If behaviors are still occurring as it approaches midnight then staff will call in a second overnight (aka PRN overnight). CEO (Chief Executive Officer) and Direct Support Services agree that this plan is reasonable since the second overnight hasn't been needed so far and it still addresses future/potential behaviors." The QAD (Quality Assurance Director) was interviewed on 10/31/14 at 11:47 AM and indicated the decision had been made to reduce staffing on the overnight shift to one person as the staff had all expressed an ability to work alone. He stated, "All of our tracking showed it was			

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	not needed," and indicated the staffing pattern where only one staff worked the overnight shift had not changed. He indicated a protocol was in place to ensure staff would be available if additional staff were needed on the overnight shift and staff could be called in to work if needed. This deficiency was cited on September 12, 2014. The facility failed to implement a systemic plan of correction to prevent reoccurrence. 9-3-3(a)			
W000191	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs. Based upon record review and interview, the facility failed to ensure staff were trained and demonstrated competency to implement 2 of 2 sampled clients' (clients	W000191	To correct the deficient practice, the Behavior Specialist has trained all staff working in the home on the BSPs. To ensure the deficient practice does not continue, the LifeDesigns Customer Specific Orientation	12/03/2014

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	#1 and #2) behavior plans (BSPs) to address maladaptive behavior. Findings included: Observations were completed at the group home on 10/29/14 from 6:50 AM until 8:55 AM. Staff #1 worked in the home with clients #1, #2 and #3 as they prepared breakfast and took medications. Staff #1 was interviewed on 10/29/14 at 7:15 AM and indicated she had not received training from the Behavior Specialist (BS) regarding client #1 and #2's behavior plans and stated, "I've only met her once." She indicated she had worked in the group home for 2 or 3 weeks. Observations were completed at the group home on 10/29/14 from 12:38 PM until 2:30 PM. The QIDP (Qualified Intellectual Disabilities Professional) and staff #1 sat with the BS reviewing clients #1 and #2's behavior plans. Client #1's record was reviewed on 10/28/14 at 6:04 PM. A BSP dated 9/14 included targeted behaviors of Enuresis/Encopresis (urinating and bowel movements intentionally occurring when not in the bathroom), calling 911, physical aggression (hitting, spitting,		Record (CSOR) will be revised to clearly indicate that training related to a Behavior Support Plan must be completed by the applicable Behavior Specialist.The CSOR must be completed and signed by the ND/Q and DORS, then submitted to the Employee Development Coordinator, prior to a new staff being added to the work schedule in the setting. Ongoing monitoring will be accomplished through the Behavior Specialist regular presence in the group home (at least weekly),and participation in team meetings.	

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	touching staff in private areas, throwing objects at others), verbal aggression (name calling, making threats towards others, asking others if he can cause harm to them). The plan indicated "Reactive strategies for verbal aggression indicate that staff should only engage in conversation with [client #1] if he's talking about topics that are calming, and to return to proactive strategies when calm...Reactive strategies for physical aggression state that if [client #1] is physically aggressive and it escalates to a level where he or others appear to be imminent danger, staff may need to use the appropriate physical intervention technique (CPI) for each unique situation in order to keep [client #1] and staff safe." Client #2's record was reviewed on 10/29/14 at 8:46 AM. A BSP dated 9/14/14 included target behaviors of physical display of frustration (screaming, crying, jumping up and down and yelling 'no'), physical aggression (kicking, slapping, pinching, hitting with objects), PICA (ingesting non-edible items such as paper, grass, dog food, raw meat, pen caps, hair bands, pencil erasers, etc), taking food/drinks (taking food or drinks from others or any food/drink sitting out), public masturbation (touching genital area when in public or			

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	around others). The interventions for the targeted behaviors did not include the removal of videos or of watching videos on the computer. Staff training records were reviewed on 10/30/14 at 11:50 AM and failed to indicate staff #1 and the QIDP were trained on client BSPs. Behavior Support Competency Evaluations were reviewed on 10/30/14 at 12:03 PM and failed to indicate staff #1 and the QIDP were trained to competency on client behavior plans. The QAD (Quality Assurance Director) was interviewed on 10/29/14 at 12:25 PM and indicated the BS was completing training with the QIDP and staff #1 as they were not present at the meeting where the previous training on client BSPs had been conducted. This deficiency was cited on September 12, 2014. The facility failed to implement a systemic plan of correction to prevent reoccurrence. 9-3-3(a)			

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W000249	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. Based upon record review and interview for 2 of 2 sampled clients (clients #1 and #2), the facility failed to ensure staff implemented clients' plans to address maladaptive behavior. Findings include: Unusual Incident Reports (UIRs) were reviewed on 10/28/14 at 6:30 PM and included the following reports: For client #1: An UIR signed on 10/23/14 completed by the TM (Team Manager) indicated on 10/20/14 at 4:30 PM indicated "Duration of behavior, 4 hours." Client #1 saw neighbor kids and made "kissing noises and taunts...DSP (Direct Support Professional) tried verbal redirection."	W000249	To correct the deficient practice, the employee who failed to follow the BSPs is no longer employed by the organization. All staff have been re-trained on the criteria required to use physical intervention (CPI). In order to prevent the deficient practice from recurrence, all staff will be trained by the Behavior Specialist prior to working as a scheduled staff in the home. Ongoing monitoring will be accomplished by a review of all incident reports by the ND/Q, Behavior Specialist, DORS and DOSS. The ND/Q or Behavior Specialist will document any needed follow-up/ corrective action on the designated space on the back of the UIR. Additionally, behavior incidents will be reviewed at team meetings at least twice a month to ensure strategies used were appropriate, and identify any additional revisions needed to the BSP.	12/03/2014

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	Writer (TM) intervened and prompted [client #1] to take a walk. [Client #1] complied. [Client #1] returned to home (sic) and continued making inappropriate comments/verbally aggressive. TM and DSP attempted verbal redirection, active ignoring, and proactive measures using careplan, but [client #1] continued. TM physically prompted [client #1] to take a walk by placing his hand on [client #1's] back. [Client #1] walked w/ (with) TM, but became agitated when a dog barked at him. When TM and [client #1] returned, TM prompted [client #1] to call his [relatives]. [Client #1] made verbal threats re: dog and others. TM directed [client #1] to take another walk, but [client #1] refused. [Client #1] dropped in the middle of the street and refused to walk. TM stood nearby as [client #1] made threats at neighbor's who passed, yelling "F___you," and "Can I kill you?" Client #1 also pulled his pants down while in the street. The TM "physically prompted [client #1] to roll to his side then stand and return to the house." Client #1 went to his room, then left his room, "and continued to be verbally aggressive., threatening staff/TM asking, "Can I kick you,"Can I spit on you," and "Can I bite you?" CM was directed to use his emotions chart in his room, and [client #1] followed TM and [staff #2] prompted client #1 to walk in the back			

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	yard. [Client #1] complied. When overnight staff #4 arrived to work in the home at 8:00 PM, she waited for client #1 to return to his room. Client #1 returned to his room, and staff #2 "stopped him from reaching [staff #4] (whom he was targeting)." Client #1 "continued to make threats, asking "Can I pick on [staff #4]?" TM "physically prompted [client #1] to continue his walk using [physical hold/escort technique]. [Client #1] walked w/ TM though he attempted to bite, kick, and spit on TM. When [client #1] finished his walk he went to his bed @ (at) 8:30 PM and remained there for the rest of the evening." A UIR dated 10/16/14 indicated client #2 "stole" [staff #6's] drink, and client #2 lost a computer video opportunity "per his plan." Client #2 was "upset about losing a video, and "starting drawing his hand back as though to hit staff....[Client #2] grabbed [client #1] by arm (sic) and dug finger nails in.....[client #2] left welts on [client #1's] arm and scraped a small amount of skin. Marks and welts were still present over an hour later." The (Network Director/QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 10/28/14 at 5:05 PM. She indicated the Team Manager (TM) was			

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	no longer working in the group home. She stated the TM "had inappropriate behavior during an incident with [client #1], and left (employment) last night. It wasn't a good fit." She stated the TM was to leave on 10/31/14, "but left today instead." She indicated client #1 had a behavioral incident yesterday with staff #2. She indicated client #1 was with the QAD (Quality Assurance Director) for a community outing. Staff #3 was interviewed again on 10/29/14 at 6:50 AM. She indicated she had never seen the TM use inappropriate CPI, but stated "I did see him being more persistent than necessary in trying to get the guys to do stuff." The QAD was interviewed on 10/29/14 at 12:30 PM. He stated the TM had not been using the CPI techniques with client #1 as a "last resort, but to gain compliance." He indicated the TM did not follow client #1's plan. The facility's reportable incidents to the BDDS since 9/26/14 were reviewed on 10/29/14 at 12:38 PM and included the following: A BDDS report dated 10/22/14 at 9:00 AM indicated client #1 "was outside with staff when he saw some girls from the			

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	neighborhood and began to make kissing noises. [Staff #2] asked [client #1] if this was an appropriate noise and [client #1] said no. He continued to make kissing noises. [TM] told [client #1] if he did not stop acting inappropriately [TM] would be led on a walk. [Staff #2] went inside the home to assist other individuals. [TM] took [client #1] on a walk around the neighborhood. [Client #1] told [staff #2] it was a CPI (Crisis Prevention Institute) walk and this was confirmed by [TM]. Later [TM] took [client #1] on a few more CPI walks in the backyard of the home throughout the evening. [Staff #2] walked with [client #1] and he willingly held her hand while walking and talking to her. At no point was [client #1's] behavior aggressive." An investigation initiated 10/23/14 indicated on 10/20/14, the TM took client #1 for a walk around the neighborhood. Client #1 told [staff #2] it was a "CPI walk," and this was confirmed by the TM. "Later the [TM] took [client #1] on a few more 'CPI' walks in the backyard of his home. [Staff #2] reported at no point was [client #1's] behavior aggressive. This report is being investigated as an allegation of violation of rights: failure to implement the behavior support plan and improper use of physical restraint." Statements indicated the QAD			

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	interviewed client #1 and client #1 "told [QAD] that they were raking leaves and he made kissing noises at the neighbor, so [TM] did CPI. [Client #1] said that made him feel angry, sad, scared and embarrassed. [Client #1] demonstrated on [QAD] how [TM] did a 'discipline walk,' but grabbing [QAD] with both arms and moving him. [Client #1] indicated there were lots of 'CPI' walks and he didn't like it...." The NDQ's statement indicated client #1 indicated to her the "CPI walks...happened no less than 5 times and he did not like CPI." The investigation indicated the unusual incident report indicated the date of the incident was 10/20/14, but the UIR (Unusual Incident Report) was 10/23/14. The QAD confirmed the date was in error and had occurred on 10/20/14. Progress notes reviewed in the investigation indicated client #1 had "NB's (not identified) from 4:30 -8:30 PM...Writer (TM) walked [client #1] each time he exhibited NB's'." (sic). Client #1's BSP was reviewed for the investigation and indicated "Reactive strategies for verbal aggression indicate that staff should only engage in conversation with [client #1] if he's talking about topics that are calming, and to return to proactive strategies when calm...Reactive strategies for physical aggression state that if [client #1] is physically aggressive and it escalates to a			

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	level where he or others appear to be in eminent (sic) danger, staff may need to use the appropriate physical intervention technique (CPI) for each unique situation in order to keep [client #1] and staff safe." The investigation indicated the allegation was "substantiated," and "Based on all the information available, including [TM's] documented account of the incident, it does appear [TM] violated [client #1's] rights by using a CPI hold when [client #1] was exhibiting verbal aggression, even though he was not a danger to himself or others." Recommendations indicated the behavior specialist "should provide additional training to staff to ensure all understand [client #1's] behavior support plan, and when it is appropriate to use physical intervention (only when [client #1] presents an eminent (sic) danger to himself or others." The investigation indicated it was completed on 10/27/14. Client #1's BSP dated September, 2014 was reviewed on 10/ 28/14 at 6:04 PM. Targeted behaviors included Enuresis/Encopresis (urinating and bowel movements intentionally occurring when not in the bathroom), calling 911, physical aggression (hitting, spitting, touching staff in private areas, throwing objects at others), verbal aggression (name calling, making threats towards			

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	others, asking others if he can cause harm to them). The plan indicated "Reactive strategies for verbal aggression indicate that staff should only engage in conversation with [client #1] if he's talking about topics that are calming, and to return to proactive strategies when calm...Reactive strategies for physical aggression state that if [client #1] is physically aggressive and it escalates to a level where he or others appear to be in imminent danger, staff may need to use the appropriate physical intervention technique (CPI) for each unique situation in order to keep [client #1] and staff safe." For client #2: 2. A BDDS report dated 10/4/14 at 1:00 PM indicated client #2 "tried to force" client #3 to drink lemonade. Staff #3 intervened, but client #2 "tried to choke her and hit her in the back." The report indicated "Writer" (TM) used an interim position hold to remove [client #2] from the area and walk him to his room. [Client #2] threw blankets at writer until writer kept them all. Writer told [client #2] that if he continued to "try to hit" he would not watch his videos on the computer. [Client #2] took a VHS tape from his closet and raised it to strike writer. Writer told [client #2] if he hit			

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	him he would lose all his tapes. [Client #2] put his VHS back and said B-A-M-B-I.' Writer replied 'If you want to watch Bambi as one of your videos you need to put all the blankets back on your bed and write your list.' [Client #2] complied. Writer noted a small finger/thumb print on the right side of [staff #3's] neck...This behavior lasted approximately 10 min (minutes)." Corrective action indicated "Review BSP and adjust actions accordingly." A BDDS report dated 10/26/14 indicated client #2 "has been taking food from glass containers and dumping them out in order to recycle. [Client #2] was asked not to dump the food and he lost a video off of his chart. [Client #2] was upset and crying about losing the video. [Client #2] grabbed writer's (unidentified) arm and [staff #3's] arm and left a mark. [Client #2] then proceeded to open and close the patio door, slamming the door hard enough to break the key off in the door." Corrective action indicated "Continue to follow BSP." Client #2's record was reviewed on 10/29/14 at 8:46 AM. A BSP dated 9/14/14 included target behaviors of physical display of frustration (screaming, crying, jumping up and down and yelling 'no'), physical aggression			

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	(kicking, slapping, pinching, hitting with objects), PICA (ingesting non-edible items such as paper, grass, dog food, raw meat, pen caps, hair bands, pencil erasers, etc), taking food/drinks (taking food or drinks from others or any food/drink sitting out), public masturbation (touching genital area when in public or around others). The interventions for the targeted behaviors did not include the removal of videos or of watching videos on the computer. The Quality Assurance Director (QAD) was interviewed on 10/31/14 at 11:47 AM and indicated the TM had not implemented clients #1 and #2's plans as written. This deficiency was cited on September 12, 2014. The facility failed to implement a systemic plan of correction to prevent reoccurrence. 9-3-4(a)			

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W000266	483.450 CLIENT BEHAVIOR & FACILITY PRACTICES The facility must ensure that specific client behavior and facility practices requirements are met. Based on observation, record review, and interview for 2 of 2 sampled clients (clients #1 and #2), and for 1 additional client (client #3), the facility failed to meet the Condition of Participation: Client Behavior and Facility Practices. The facility failed to implement its policy and procedures to prevent neglect by failing to develop and implement effective corrective action to address the physically and verbally aggressive and sexually inappropriate behavior of client #1 and the physically aggressive behavior of client #2. Findings include: 1. The facility failed to ensure staff were trained and demonstrated competency to implement 2 of 2 sampled clients' (clients #1 and #2) behavior plans (BSPs) to address maladaptive behavior. Please refer to W191. 2. The facility failed for 2 of 2 sampled clients (clients #1 and #2), to ensure staff implemented clients' plans to address maladaptive behavior. Please refer to	W000266	W191, W249 The employee who failed to follow the BSPs is no longer employed by the organization. To correct the deficient practice, the Behavior Specialist has trained all staff working in the home on the BSPs. All staff have been re-trained on the criteria required to use physical intervention (CPI). To ensure the deficient practice does not continue , all staff will be trained by the Behavior Specialist prior to working as a scheduled staff in the home. The LifeDesigns Customer Specific Orientation Record (CSOR) will be revised to clearly indicate that training related to a Behavior Support Plan must be completed by the applicable Behavior Specialist. The CSOR must be completed and signed by the ND/Q and DORS, then submitted to the Employee Development Coordinator, prior to a new staff being added to the work schedule in the setting. Ongoing monitoring will be accomplished through the Behavior Specialist regular presence in the group home(at least weekly), and participation in team meetings. All incident reports will be reviewed by the ND/Q, Behavior Specialist, DORS and DOSS. The ND/Q or	12/03/2014

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	W249. 3. The facility failed to implement its policy and procedures to prevent neglect by failing to develop and implement effective corrective action to address the physically and verbally aggressive and sexually inappropriate behavior of client #1 and the physically aggressive behavior of client #2. Please refer to W274. This condition was cited on September 12, 2014. The facility failed to implement a systemic plan of correction to prevent reoccurrence. 9-3-5(a)		Behavior Specialist will document any needed follow-up/ corrective action on the designated space on the back of the UIR. Additionally, behavior incidents will be reviewed at team meetings at least twice a month to ensure strategies used were appropriate, and identify any additional revisions needed to the BSP. W274 The Behavior Support Plans were revised for all young men living in the home only 2 months ago, and have undergone a number of revisions/ enhancements, as a result of ongoing feedback from staff, based on their observations and experiences. At the same time the new BSPs were implemented, new activity schedules were introduces, involving the men in a wider variety of activities, and placing a higher level of expectations on them in regards to more community involvement,as well as expectations to increase independence at home. While it is true that interfering behaviors have not been completely eliminated, there has been a significant decrease in the frequency and severity of behaviors, and an increase in staff's ability and competence to respond in a consistent and appropriate manner. Staff will continue to meet at least twice per month, and will review all behavioral incidents and determine if strategies are	

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			effective, or if revisions to the BSPs are necessary. The Behavior Specialist continues to observe customers living in the home at least weekly, and is available by phone for consultation. She also trains each new staff on the BSPs to ensure competency. Ongoing monitoring will be accomplished through the Residential Services Monthly Report, which provides a compilation of BDDS report information, as well as behavior data, and is disseminated to the IST for review. The ND/Q is in the home no less than twice per week to provide ongoing monitoring and support to staff, as well as to review all behavioral data. The DORS is in the setting no less than monthly, and the CEO will complete a quarterly on-site review.	
W000274	483.450(b)(1) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The facility must develop and implement written policies and procedures that govern the management of inappropriate client behavior. Based on record review and interview, the facility failed to implement its policy and procedures to prevent neglect by failing to develop and implement effective corrective action to address the physically and verbally aggressive and sexually inappropriate behavior of client	W000274	The Behavior Support Plans were revised for all young men living in the home only 2 months ago, and have undergone a number of revisions/enhancements, as a result of ongoing feedback from staff, based on their observations and experiences. At the same time the new BSPs were implemented,new activity	12/03/2014

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	#1 and the physically aggressive behavior of client #2. Findings include: Unusual Incident Reports (UIRs) were reviewed on 10/28/14 at 6:30 PM and included the following reports: For client #1: An UIR dated 9/29/14 indicated client #1 got out of bed at 9:00 PM and stated that he "wanted to pick on [staff #4]." Client #1 "proceeded to make rude gestures and asked about Jubilee dessert (which had been the trigger of a previous behavior incident) and reached for his shorts." Client #1 was redirected from urinating on the floor. Staff #3 redirected client #1 to his room and redirected client #1 to breathing exercises and implemented rubbing client's #1 back with finger tips and discussed calming techniques for client #1 to use. An UIR dated 10/4/14 at 1:00 PM indicated client #1 was brought back early from a visit with a relative to attend a Special Olympic bowling event. On the way to the event, client #1, "yelled wiener", calmed down, then went into the bowling alley to play video games. Once his money was gone, client #1 "flipped		schedules were introduces, involving the men in a wider variety of activities, and placing a higher level of expectations on them in regards to more community involvement, as well as expectations to increase independence at home. While it is true that interfering behaviors have not been completely eliminated, there has been a significant decrease in the frequency and severity of behaviors, and an increase in staff's ability and competence to respond in a consistent and appropriate manner. Staff will continue to meet at least twice per month, and will review all behavioral incidents and determine if strategies are effective, or if revisions to the BSPs are necessary. The Behavior Specialist continues to observe customers living in the home at least weekly,and is available by phone for consultation. She also trains each new staff on the BSPs to ensure competency. Ongoing monitoring will be accomplished through the Residential Services Monthly Report, which provides a compilation of BDDS report information, as well as behavior data, and is disseminated to the IST for review. The ND/Q is in the home no less than twice per week to provide ongoing monitoring and support to staff, as well as to review all behavioral data. The DORS is in the setting no less	

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	off" (profane gesture) staff from another group home. The incident report indicated during the incident client #1 hit and grabbed client #2, and upon returning home, "walked around the house kicking the house and banging on windows. When [client #1] saw that staff wasn't reacting to him beating on the house windows, he went to the neighbors house," rang their doorbell and attempted "to beat on" the neighbor's windows, but was redirected by staff. Client #1 "ruminated" about the police being called (no indication police were called in the report) and whether the neighbors would call police. Client #1 remained on their porch for an hour until the TM (Team Manager) on call arrived and escorted client #1 off the neighbor's property. Client #1 then tried to go to another neighbor's house, but was redirected, and continued to make "rude remarks and obscene gestures throughout the entire evening." After client #1 returned to the group home, he opened his bedroom window, "several times" pulled down his pants and "flipped off" the neighbors. Client #1 "eventually calmed down," then went on a van ride with clients #2 and #3 and 2 overnight staff. An UIR dated 10/5/14 (time not indicated) indicated while staff (unidentified) was preparing breakfast		than monthly, and the CEO will complete a quarterly on-site review.	

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	and staff #5 was preparing medications for administration, client #1 asked if staff #5 was going to "call the cops" or if neighbors would call the cops. Client #1 called the police from the group home office and when they arrived, client #1 "exposed his genitals" to police and tried to "grab" them as they left. The report indicated during the conversation between client #1 and police "that it was inappropriate to prank call police and next time it might not just be a talking to." Client #1 sat in the office with staff #5 and "ruminated on calling the police, going to Oktoberfest, getting neighbors to call the police." Client #1 "proceeded to try and exit residence stating that he was going to make them 'call the cops'." There was no indication client #1 left the group home during the incident. Client #2 went on an outing and client #3 went home while staff #5 stayed with client #1. An UIR signed on 10/23/14 completed by the TM indicated on 10/20/14 at 4:30 PM indicated "Duration of behavior, 4 hours." Client #1 saw neighbor kids and made "kissing noises and taunts...DSP (Direct Support Professional) tried verbal redirection." Writer (TM) intervened and prompted [client #1] to take a walk. [Client #1] complied. [Client #1] returned to home and continued making inappropriate comments/verbally			

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	aggressive. TM and DSP attempted verbal redirection, active ignoring, and proactive measures using careplan, but [client #1] continued. TM physically prompted [client #1] to take a walk by placing his hand on [client #1's] back. [Client #1] walked w/ (with) TM, but became agitated when a dog barked at him. When TM and [client #1] returned, TM prompted [client #1] to call his [relatives]. [Client #1] made verbal threats re: dog and others. TM directed [client #1] to take another walk, but [client #1] refused. [Client #1] dropped in the middle of the street and refused to walk. TM stood nearby as [client #1] made threats at neighbors who passed, yelling "F___you," and "Can I kill you?" Client #1 also pulled his pants down while in the street. The TM "physically prompted [client #1] to roll to his side then stand and return to the house." Client #1 went to his room, then left his room, "and continued to be verbally aggressive, threatening staff/TM asking, 'Can I kick you,'Can I spit on you,' and 'Can I bite you?'" Client #1 was directed to use his emotions chart in his room, and "[client #1] followed TM and [staff #2] prompted client #1 to walk in the back yard. [Client #1] complied." When overnight staff #4 arrived to work in the home at 8:00 PM, she waited for client #1 to return to his room. Client #1			

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	returned to his room, and staff #2 "stopped him from reaching [staff #4] (whom he was targeting)." Client #1 "continued to make threats, asking 'Can I pick on [staff #4]?'" TM "physically prompted [client #1] to continue his walk using [physical hold/escort]. [Client #1] walked w/ TM though he attempted to bite, kick, and spit on TM. When [client #1] finished his walk he went to his bed @ (at) 8:30 PM and remained there for the rest of the evening." There was no evidence of corrective action. An UIR dated 10/26/14 from 8:25 PM-10:00 PM indicated "Duration of the behavior 1 hour, 54 minutes." Staff #3 left at 8:25 PM along with staff #1 as client #1 was lying down in his room "and all residents were quiet and in their bed (sic). On call [TM] had called staff back at 8:00 PM. Staff #1 talked to [TM] on phone then staff #1 informed me that TM told her that one of us had to stay until 10 PM (if there was an issue) even after [staff #1] made it clear that she couldn't ...and [staff #3's] car was being worked on so [staff #3] didn't have a way home. Staff #3 received a phone call from [TM] asking writer to come back because [staff #4] had called and asked [staff #5] to come in due to [client #1] coming out of his room and finding [staff #4] and (client #1) making the statement			

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	"You choked me, I'm going to call the cops. [Staff #5] claimed to have tried to reach [TM] by phone and pager but was unsuccessful. Staff did not successfully reach the on call [TM] after he called the house at 8:00 PM." Staff #3 arrived at the house at 8:34 PM, staff #4 stepped out of client #1's sight, and client #1 was directed into his room by staff #3. "Ten minutes later, [client #1] came out of room (sic), stating "Can I pick on [staff #4]?" [Client #1]...opened [client #2's] door and ran for [client #2's] bed. [Staff #3] used approved CPI escort to remove [client #1] from room and prevent [client #2] from coming to harm. Client #1 returned to his room and was asleep by 10:05 PM." An UIR dated 10/27/14 indicated "Duration of behavior; 1 hour, 45 minutes." Client #1 asked staff if he could get a butter knife and hurt people with it. Client #1 made kissing noises at the neighbor's houses and "ruminated" regarding calling the cops and having CPI used on him. Client #1 beat on the counters with a metal spoon and "threatened to hit some of the other individuals with it." Client #1 "mentioned to [staff #2] that he was acting like this because he had anxiety about the TM's being here because he didn't want to be CPI escorted anymore."			

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	When the TM came to the group home, client #1 "started asking the TM if he was going to do CPI on him." Client #1 went to one of the neighbor's house and "attempted to ring the door bell and flip them off." Client #1 asked if the neighbors would call the police, and was redirected off the neighbor's property. While walking from the neighbor's property client #1 "decided to go on another neighbor's property and attempt to ring their doorbell and upset them." The group home nurse, NDQ (Network Director/Qualified Intellectual Disabilities Professional), and staff #1 and #2 were able to redirect client #1 back to the group home and client #1 assisted staff #2 in making dinner. "When the TM came in with the other individuals, [client #1] started getting worked up again. He went into the living room where individual [client #3] was trying to watch a movie and started sticking that individual's exercise band in his mouth in an attempt to upset [client #3]. He was also mocking the [TM] a lot." Staff #2 redirected client #1 back to his room and talked to him about why he was getting himself worked up again after he had just calmed down. [Client #1] told [staff #1] that he still had anxiety about the [TM] and being CPI escorted....." There was no evidence of corrective action in the report.			

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	An UIR dated 10/27/14 from 9:45 PM -11:30 PM indicated "Duration of behavior 1 hour and 45 minutes." Client #1 "got out of bed and asked where the overnight person was because he wanted to tease her." Staff #2 "went to help [client #1] calm down and go back to bed. [Client #1] insisted on staying up late and yelling inappropriate words trying to wake up the other consumers." Client #1 got his ventriloquist dummy and "started making inappropriate gestures and saying inappropriate things about the dummy." Client #1 called a relative twice and the QAD (Quality Assurance Director) and spoke about fishing before going back to bed. Staff #2 "rubbed [client #1's] arm and hand upon his request, and scratched his back until he was ready to go to sleep." There was no evidence of corrective action in the report. For client #2: An UIR dated 10/4/14 MR at 4:00 PM indicated client #2 tried to drink from a beer tap behind the bar at a bowling alley before staff could intervene. Client #2 attempted to drink from the tap and yelled "Just one beer" and left the bowling alley after Special Olympic staff			

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	told him and staff #3 the police would be called if his behavior did not stop. He exited the bowling alley before police were called. The report indicated client #2 was now banned from the bowling alley. An UIR dated 10/16/14 indicated client #2 "stole" [staff #6's] drink, and client #2 lost a computer video opportunity "per his plan." Client #2 was "upset about losing a video," and "starting drawing his hand back as though to hit staff....[Client #2] grabbed [client #1] by arm (sic) and dug finger nails in.....[client #2] left welts on [client #1's] arm and scraped a small amount of skin. Marks and welts were still present over an hour later." There was no evidence of corrective action in the report. Staff #2 was interviewed on 10/28/14 at 5:08 PM. When asked about the incident with client #1 she stated, "We got through it." She stated the QAD was in the group home "occasionally." The QAD was interviewed on 10/28/14 at 5:25 PM. When asked about reportable incidents to the BDDS office, he indicated they would be available in the morning and stated, "There are a lot of them."			

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	Staff #3 was interviewed again on 10/29/14 at 6:50 AM. She indicated she had never seen the TM use inappropriate CPI, but stated "I did see him being more persistent than necessary in trying to get the guys to do stuff." She indicated client #2 also had an earning program for computer use and indicated if client #2 took something that was not his, he would lose an opportunity for using the computer. If he returns the item, he can re-earn the use of the computer. She indicated client #2 used laminated pictures of computers as a visual aid to earning the computer time. She indicated she was with client #2 at the bowling alley when he attempted to drink beer and stated, "I was right behind him." When asked about overnight staff, she stated, "They've discontinued 2 overnights (staff) since last Wednesday. They asked everyone if they felt comfortable. These guys once they're asleep, they're asleep. I was by myself last night." She indicated the overnight staff stayed until clients #2 and #3 left for the day. She indicated the clients usually were asleep by 8:00 PM and stated "By 10:00 PM everyone is asleep." She indicated the overnight staff worked from 8:00 or 10:00 PM until 8:00 AM. The QAD was interviewed on 10/29/14 at 12:30 PM. When asked about the			

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	investigation in regards to the TM using a CPI escorted walk with client #1, he indicated the Director of Support Services (DSS) had completed the investigation. He indicated the TM had worked in the group home under the supervision of administrative staff until the investigation had been completed. He stated the TM had not been using the CPI techniques with client #1 as a "last resort, but to gain compliance." He indicated the TM did not follow client #1's plan. The Behavior Specialist (BS) was interviewed on 10/29/14 at 12:40 PM and when asked how frequently she visited the home, she stated, "As behaviors are better, I'm available via phone. I come one time weekly and take phone calls from parents and staff. (I complete) random visits as part of our rotation (of monitoring)." The facility's reportable incidents to the BDDS since 9/26/14 were reviewed on 10/29/14 at 12:38 PM and included the following: 1. A BDDS report dated 9/26/14 at 4:10 PM indicated client #1 was at the dinner table eating chicken when he made the statement "the bone looked like poop. He began obsessing over it...and began to target [client #2] and grabbed the back of			

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	his shirt...He began laughing loudly in [client #2's] ear. [Client #1] left the room then went after the roommate (client #3) again and scratched his neck. [Client #1] found a butter knife in the kitchen and said he was going to stab [client #2]. Staff removed the butter knife and took housemates to the back porch. Staff called the house manager for assistance. While waiting outside [client #1] pulled the fire alarm." Corrective action indicated a peer-to-peer investigation would be completed. A BDDS report dated 9/26/14 at 5:30 PM indicated client #1 "was in a drawn out behavior when he pulled the fire alarm. The alarm security company called the group home and staff acknowledged that there was no fire but emergency services came anyway. They toured the house to confirm there was no fire and left. Corrective action indicated "Staff will address the issue of [client #1] continuing to pull fire alarms at the staff meeting on Monday morning (9/26/14). The Team Manager (TM) and QAD (Quality Assurance Director) will make contact with the alarm company and confirm the protocol for calling off false alarms." A BDDS report dated 10/1/14 at 12:30 PM indicated client #1 started yelling "wiener" and "hysterically laughing...On			

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	arrival, one staff took the other two clients into the bowling alley to bowl while the other staff stayed in the van with [client #1] trying to calm him down." When he was calm, client #1 went into the bowling alley and played video games in the arcade. When client #1 ran out of money, he started "ruminating about Oktoberfest, how his toy he won looked like poop, and the word 'penis'." After calming down he recognized an individual from another group home and begin "flipping her off and yelling about how his toy looked like her poop." Staff helped the other two clients finish bowling then they all headed home. "On the way home, [client #1] grabbed and hit [client #2], then threw objects at him. Staff had [client #2] move to the back of the van away from [client #1] and while doing so [client #1] tried to poke [client #2] with a hula hoop." Corrective action indicated an "IDT meeting will convene today to discuss the incident and develop plan of action for [client #1's] continued aggression." A BDDS report dated 10/22/14 at 9:00 AM indicated client #1 "was outside with staff when he saw some girls from the neighborhood and began to make kissing noises. [Staff #2] asked [client #1] if this was an appropriate noise and [client #1]			

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	said no. He continued to make kissing noises. [TM] told [client #1] if he did not stop acting inappropriately [client #1] would be led on a walk. [Staff #2] went inside the home to assist other individuals. [TM] took [client #1] on a walk around the neighborhood. [Client #1] told [staff #2] it was a CPI (Crisis Prevention Institute) walk and this was confirmed by [TM]. Later [TM] took [client #1] on a few more CPI walks in the backyard of the home throughout the evening. [Staff #2] walked with [client #1] and he willingly held her hand while walking and talking to her. At no point was [client #1's] behavior aggressive." Corrective action indicated "an investigation into potential abuse is underway." A BDDS report dated 10/26/14 at 8:25 PM and reported on 10/28/14 indicated client #1 came out of his room after going to bed and told [staff #4] "You choked me. I am going to call the cops." [Staff #3] returned the (sic) when [staff #4] called her to assist. Calls by [staff #1], [staff #4] and [staff #3] to on call and cell of [TM] went unanswered. [Staff #3] had [staff #4] step out of [client #1's] sight and worked with continuing behaviors until 10:05 PM when [client #1] fell asleep." Behaviors included client #1 going into client #2's room and			

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	running toward client #2 in bed. "A CPI escort was necessary to remove [client #1] from [client #2's] room. [Client #1] then pounded on [client #2's] door, turned the thermostat up to 99 degrees and then down to 22 degrees all in an attempt to bother [clients #2 and #3]. [Client #1] engaged in obsessive thought patterns about pulling the fire alarm. [Staff #3] redirected [client #1] each time. When [client #1] decided to pull [client #3] out of bed, [staff #3] blocked him and re-directed him to bed. [Client #1] finally laid down on his bed and asked [staff #3] for reassurance she was on his side. [Staff #3] answered that she was there to support him. [Staff #3] rubbed [client #1's] back for 20 minutes until [client #1] fell asleep." Corrective action indicated "Review actions of on call and supervisor [TM] to see if failed (sic) to provide support to [client #1] and staff. Add additional staff to Ridgeview roster. Review [client #1's] recent rash of behaviors." A BDDS report dated 10/27/14 at 9:45 PM indicated "[client #1] got out of bed and asked where the overnight person was because he wanted to tease her. [Staff #2] worked with [client #1] to calm him down so he could go back to bed. [Client #1] insisted on staying up and was yelling inappropriate words			

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	trying to wake up other consumers. [Client #1] spoke with [relative] twice during the behavior. [Relative] tried assist (sic) with calming down and going to sleep. [Client #1] asked to talk to [QAD] after his second call to [relative]. [QAD] and [client #1] discussed fishing and things that make [client #1] happy. [Client #1] then got his ventriloquist dummy and started making inappropriate gestures and saying inappropriate things. [Client #1] calmed down and gave [staff #1] the dummy and his pirate hat in the office. [Staff #2] rubbed [client #1's] arms and hands upon [client #1's] request and as approved for calming [client #1] until [client #1] was ready for sleep." Corrective action indicated "IDT will convene to discuss the incident and develop a plan of action for [client #1's] continued aggression." Client #1's BSP dated September, 2014 was reviewed on 10/28/14 at 6:04 PM. Targeted behaviors included Enuresis/Encopresis (urinating and bowel movements intentionally occurring when not in the bathroom), calling 911, physical aggression (hitting, spitting, touching staff in private areas, throwing objects at others), verbal aggression (name calling, making threats towards others, asking others if he can cause harm to them). The plan indicated "Reactive			

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	strategies for verbal aggression indicate that staff should only engage in conversation with [client #1] if he's talking about topics that are calming, and to return to proactive strategies when calm...Reactive strategies for physical aggression state that if [client #1] is physically aggressive and it escalates to a level where he or others appear to be in imminent danger, staff may need to use the appropriate physical intervention technique (CPI) for each unique situation in order to keep [client #1] and staff safe." There was no indication of which CPI techniques to use or hierarchy for their use. The BSP did not include physical interventions as a reactive strategy for verbal aggression. For client #2: A BDDS report dated 10/4/14 at 1:00 PM indicated client #2 "tried to force" client #3 to drink lemonade. Staff #3 intervened, but client #2 "tried to choke her and hit her in the back." The report indicated "Writer" (unidentified) used an interim position hold to remove [client #2] from the area and walk him to his room. [Client #2] threw blankets at writer until writer kept them all. Writer told [client #2] that if he continued to "try to hit" he would not watch his videos on the computer. [Client #2] took a VHS tape			

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	from his closet and raised it to strike writer. Writer told [client #2] if he hit him he would lose all his tapes. [Client #2] put his VHS back and said B-A-M-B-I.' Writer replied 'If you want to watch Bambi as one of your videos you need to put all the blankets back on your bed and write your list.' [Client #2] complied. Writer noted a small finger/thumb print on the right side of [staff #3's] neck...This behavior lasted approximately 10 min (minutes)." Corrective action indicated "Review BSP and adjust actions accordingly." A BDDS report dated 10/4/14 at 2:30 PM indicated client #2 went bowling in another city. "Right before it was time to leave the bowling alley [client #2] walked over to the bar at the alley with staff right behind him. [Client #2] grabbed a cup and tried to pour himself a beer from the tap. Staff dumped it out and [client #2] continued to try and get more cups. Staff attempted to redirect [client #2] but [client #2] kept saying 'one beer'." Staff said 'no beer' and [client #2] attempted to drink out of the tap itself. [Client #2] had a strong grip on it and was spilling beer on the floor. The second staff arrived at this point and got [client #2] out from behind the bar. [Client #2] then fell to the floor and began yelling and banging his hands on the floor. A			

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	Special Olympics staff then told Ridgeview staff and [client #2] that if this continued they would have to call the police. After repeating this to [client #2] a couple of times he stopped and then calmed down and left with staff." Corrective action indicated "Emergency IDT will convene today to discuss the incident and determine measures to address the incident." A BDDS dated 10/18/14 indicated client #2 "opened the office and drank writer's (unidentified) coffee...One staff took one of [client #2's] videos off of his picture chart. Staff explained why he lost the video-for stealing." Client #2 began to "get upset and began to yell that he wanted 'F-I-V-E'!" Client #2 "dug his nails" into writer's arm, then took a quarter and began hitting the writer in the arm with the quarter. Client #2 grabbed the arm of unidentified staff and threw change, hitting writer. Writer collected the money and gave it to staff. This caused client #2 "to begin yelling about money." Client #2 was given the money when he calmed down. Corrective action indicated "Continue to document negative behaviors and follow BSP. A BDDS report dated 10/26/14 indicated client #2 "has been taking food from glass containers and dumping them out in			

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	order to recycle. [Client #2] was asked not to dump the food and he lost a video off of his chart. [Client #2] was upset and crying about losing the video. [Client #2] grabbed writer's (unidentified) arm and [staff #3's] arm and left a mark. [Client #2] then proceeded to open and close the patio door, slamming the door hard enough to break the key off in the door." Corrective action indicated "Continue to follow BSP." Client #2's record was reviewed on 10/29/14 at 8:46 AM. A BSP dated 9/14/14 included target behaviors of physical display of frustration (screaming, crying, jumping up and down and yelling 'no'), physical aggression (kicking, slapping, pinching, hitting with objects), PICA (ingesting non-edible items such as paper, grass, dog food, raw meat, pen caps, hair bands, pencil erasers, etc), taking food/drinks (taking food or drinks from others or any food/drink sitting out), public masturbation (touching genital area when in public or around others). The interventions for the targeted behaviors did not include the removal of videos or of watching videos on the computer. 3. A BDDS dated 9/26/14 indicated client #3 was "very agitated when he woke up in the morning around 5:45 AM. He has a			

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	history of 'cycling' where he becomes increasingly agitated and it leads to outbursts of aggression. The previous day the Human Rights Committee had approved a prescribed PRN (as needed) for just such instances. Staff tried all the proactive measures written in his protocol to try and calm him down. They did not succeed and as he became increasingly agitated the [Team Manager] called [LPN] (licensed practical nurse)], and agency nurse, at 6:30 AM and described the situation. She recommended the use of the PRN Ativan. It was administered per protocol and [client #3] was monitored and encouraged to relax. He lay on the couch and watch a favorite movie. Staff said he seem (sic) to calm down a bit but still showed signs of agitation." Corrective action indicated the team manager will continue to monitor and follow protocol as written and provide feedback to the director of quality assurance and the LPN. A BDDS report dated 9/26/14 at 12:30 PM indicated client #3 required an additional PRN medication as he "continued to become more agitated as the day progressed, pacing and rubbing his hands together in the way that commonly precedes such acts of aggression..." Corrective action indicated			

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	client #3's response to the PRN medication would be monitored. A BDDS report dated 9/26/14 at 7:18 PM indicated client #3 was looking at videos on his electronic tablet and client #2 came into the room and attempted to take it from him. Client #3 then "gravved (sic) [client #2] and left a red ring around his neck and ripped his shirt fighting him to get his ipad back. When staff (unidentified) went to separate the two [client #3] grabbed her (staff) and removed her shirt and bra as well." The report indicated the house manager restrained client #3 and held him on the ground for a minute until he was calm. Corrective action indicated a peer to peer investigation would be completed. Client #3's BSP dated September, 2014 was reviewed on 10/29/14 at 8:40 AM. Targeted behaviors indicated physical aggression (pulling shirt off of others), self injurious behavior (rubbing fingers together until they are raw), elopement (climbing out of windows, running away from staff). The plan included the use of Vistaril 25 mg (milligrams) as needed for insomnia and Ativan .5 mg one tablet by mouth every 6 hours as needed for agitation. The plan indicated for physical aggression "if [client #3] continues to be physically aggressive and it escalates to a			

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	level where he or others appear to be in imminent danger, staff may need to use the appropriate physical intervention technique (CPI) for each unique situation in order to keep [client #3] and the staff safe." Staff #3 and staff #1 were interviewed on 10/29/14 at 8:30 AM. When asked about the incident dated 10/26/14 in which staff #3 she was called back to work after leaving for the night, staff #3 stated, "Everything was quiet when we left," and client #1 "was on his way to sleep." Staff #3 stated, "He's been known to get up after being asleep for an hour." Staff #1 indicated she took staff #1 to her car and staff #3 indicated staff #4 was alone with client #1 "a half hour or less." Staff #1 and #3 indicated they were unable to reach the TM who was on call to address the staffing needs of the home. Continuing Education Records were reviewed on 10/30/14 at 11:50 AM and included the following: 9/22/14: ".... TM talked about staffing; [Staff #4] wants to move to another location; uncomfortable working alone overnight...." 9/24/14; TM was trained on BDDS reporting; how to complete and what are			

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	reportable incidents. 9/29/14; indicated the TM, staff #4, staff #2, staff #6, staff #3 and the QAD were present for training on clients #1, #2 and #3's BSPs. 10/6/14; indicated the TM, staff #6, staff #2, staff #3 and staff #4 were trained regarding BSP competency evaluations for clients #1, #2 and #3. 10/13/14 indicated new goals for clients #1 and #2 were reviewed, and the schedule for the next two weeks was reviewed. 10/22/14 Team meeting notes indicated with staff #7, TM and NDQ present indicated "Staff is not to have drinks, coffee and soft drinks especially in the house of the customers. It was emphasized that this is the customer's home and we all know that some customers takes (sic) and either gulp them or give them to another customer. If this happens, staff needs to review their own behavior and how it affected the situation....On call pager: [NDQ] stated that the on call pager is assigned from Monday to Monday." 10/22/14; group home meeting indicated staff #1, #3, #5, and the TM were trained			

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	regarding medication administration. Minutes indicated the BS had provided training for client #2's goals, and use of a choice board. 10/29/14 group home meeting minutes indicated staff #1, #2, #3, #5, the group home nurse, the NDQ and the BS were present at the meeting conducted by the QAD. The minutes indicated a review of goals for clients #1, #2, and #3, thoroughly completing progress notes, "Please keep drinks in your car!,...[client #1's] new behavioral PRN order-[nurse] working with (sic) the doctor to figure out a solution." Notes attached to the minutes indicated staff #3 would be working alone overnight from Monday through Thursday, all day on Saturday and Sunday and staff #4 would work overnight from 10:00 PM to 6:00 AM. There was no evidence of staff training regarding client #1's behavior plan and the use of CPI techniques, or of reporting abuse, neglect and mistreatment requirements. IDT meeting minutes dated 10/5/14 regarding the 10/4/14 incidents involving clients #1 and #2 on 10/4/14 were reviewed on 10/28/14 at 5:45 PM and indicated the following recommendations: 1. "Behavior specialist (BS) following			

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	up with [client #1's] psychiatrist about a behavioral PRN (as needed medication)." 2. "Adjust [client #1's] earning program to lengthen or change the period of earning." 3. "Speak with [clients #3 and #1's] families about scheduling visits further in advance." 4. "Consider writing drink seeking component to [client #2's] behavior plan." 5. "Remindi ng staff that rubbing [client #1's] back helps in calming him down." 6. "Have [staff #7] stay today until [client #1] wakes up to help with potential behaviors." 7. "Have someone (BS, staff #7, or Quality Assurance Director (QAD) follow up with the neighbors." 8. "QAD is available as backup staff for this evening if behaviors continue." Emergency IDT meeting minutes for the 9/26/14 incident were reviewed on 10/30/14 and indicated the following: For client #1: -"Reminding all visitors to moving to the office (sic) and shutting the door during behaviors" -"Re-directing [client #1] either to his room, a car ride, or a walk"			

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	-"Moving other customers and staff away from the immediate vicinity" -"Build potential loss of extra activities into earning program for negative behavior" For client #2: -"Getting [client #2] his own computer-set up in living room, set times of day, make a goal" -"Encourage writing instead of printing" For client #3 -"Ativan PRN seemed to help during the day" -"Encouraging [client #3] to use his ipad in his room (not restricting, just encouraging him) -Assuring staff are in the living room with the guys whenever more than one is in there" IDT meeting minutes dated 10/24/14 were reviewed on 10/30/14 at 5:10 PM and indicated "staff said they are comfortable with just a single staff. The only note was that if there were behaviors actively going on it would be helpful if a second overnight (sic) would be called in Per Required Need....The QAD suggests implementing a protocol where if one of the residents are actively exhibiting behaviors into the evening shift then one			

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	of the two evening shift staff would stay until midnight to make sure they are available for behavioral support. If behaviors are still occurring as it approaches midnight then staff will call in a second overnight (aka PRN overnight). CEO (Chief Executive Officer) and Direct Support Services agree that this plan is reasonable since the second overnight hasn't been needed so far and it still addresses future/potential behaviors." There was no indication in the meeting minutes of an investigation or corrective action/preventive steps in regards to the incidents dated 10/5/14, 10/26/14 and 10/27/14 regarding client #1's behavior, or of the incident dated 10/16/14 regarding client #2's behavior. Investigations were reviewed on 10/30/14 at 5:10 PM and indicated the following: An investigation dated 9/29/14 into the incident dated 9/26/14 indicated client #1 scratched client #2's neck and pulled his shirt, and pulled the fire alarm. Recommendations indicated "Group home staff and IDT should meet to de-brief the situation and discuss the effectiveness of the behavior plan, as well as both proactive and reactive techniques that could have helped the situation. The			

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	agency's Behavior Specialist should be consulted to determine if changes to the plan need to be made. Findings should be forwarded to the CEO, DoSS (Director of Support Services) and QAD for review." An investigation dated 10/5/14 and completed 10/5/14 indicated client #1 had been "upset at the bowling alley and chose not to bowl. He had been upset about coming home early from a visit with his mother. At the alley he began to ruminate about 'Oktoberfest,' how his toy looked like poop, and the word 'penis'. On the drive home, [client #1] grabbed [client #2's] shirt and threw undefined 'objects' at him. Staff had [client #2] move to the back of the van and sat between them, but [client #1] used a hula hoop to try and poke [client #2]." Recommendations indicated "The behaviors are addressed in [client #1's] behavior plan, but the incidents from the day should be discussed with an IDT de-briefing to occur within two days. Any further findings and recommendations should be forwarded to the DSS (Director of Support Services) and CEO." An investigation initiated 10/23/14 indicated on 10/20/14, the TM took client #1 for a walk around the neighborhood. Client #1 told [staff #2] it was a "CPI walk," and this was confirmed by the			

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	TM. "Later the [TM] took [client #1] on a few more 'CPI' walks in the backyard of his home. [Staff #2] reported at no point was [client #1's] behavior aggressive. This report is being investigated as an allegation of violation of rights: failure to implement the behavior support plan and improper use of physical restraint." Statements indicated the QAD interviewed client #1 and client #1 "told [QAD] that they were raking leaves and he made kissing noises at the neighbor, so [TM] did CPI. [Client #1] said that made him feel angry, sad, scared and embarrassed. [Client #1] demonstrated on [QAD] how [TM] did a 'discipline walk,' by grabbing [QAD] with both arms and moving him. [Client #1] indicated there were lots of 'CPI' walks and he didn't like it...." The NDQ's statement indicated client #1 indicated to her the "CPI walks...happened no less than 5 times and he did not like CPI." The investigation indicated the unusual incident report indicated the date of the incident was 10/20/14, but the UIR (Unusual Incident Report) was 10/23/14. The QAD confirmed the date was in error and had occurred on 10/20/14. Progress notes reviewed in the investigation indicated client #1 had "NB's (not identified) from 4:30 -8:30 PM...Writer (TM) walked [client #1] each time he exhibited NB's'." (sic). Client #1's BSP was reviewed for			

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	the investigation and indicated "Reactive strategies for verbal aggression indicate that staff should only engage in conversation with [client #1] if he's talking about topics that are calming, and to return to proactive strategies when calm...Reactive strategies for physical aggression state that if [client #1] is physically aggressive and it escalates to a level where he or others appear to be in eminent (sic) danger, staff may need to use the appropriate physical intervention technique (CPI) for each unique situation in order to keep [client #1] and staff safe." The investigation indicated the allegation was "substantiated," and "Based on all the information available, including [TM's] documented account of the incident, it does appear [TM] violated [client #1's] rights by using a CPI hold when [client #1] was exhibiting verbal aggression, even though he was not a danger to himself or others." Recommendations indicated the behavior specialist "should provide additional training to staff to ensure all understand [client #1's] behavior support plan, and when it is appropriate to use physical intervention (only when [client #1] presents an eminent (sic) danger to himself or others." The investigation indicated it was completed on 10/27/14. There was no indication in the			

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	investigations provided of corrective action/preventive steps in regards to the incidents dated 10/5/14, 10/26/14 and 10/27/14 regarding client #1's behavior, or of the incident dated 10/16/14 regarding client #2's behavior. The Quality Assurance Director (QAD) was interviewed on 10/31/14 at 11:47 AM. He indicated the incident dated 10/20/14 had not been reported timely, and indicated the TM had continued to work in the group home after the incident where he used CPI escort as to gain compliance for client #1 on 10/20/14. He indicated the TM did not work alone, and was under the supervision of the NDQ. He stated, "In hindsight, he shouldn't have worked" until the investigation into the incident was completed. He indicated he was aware of the incidents on 10/4/14 and on 10/5/14 in which client #1 called police, attempted to grab police officers, exposed himself to police and neighbors, and rang neighbors doorbells. He indicated the incident dated 10/26/14 in which client #1 stated staff #5 had choked him was not investigated. He indicated the incident dated 10/1/14 regarding client #1's behavior at the bowling alley was in error and the incident occurred on 10/4/14. He indicated the incidents of physically aggressive behavior between clients were			

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	not always formally investigated, but each incident went through a de-briefing process at the weekly team meetings to discuss proactive steps to take to prevent future occurrence. He indicated while client behaviors had improved since the last survey, the facility still was in process of completing corrective action to address client behaviors. The facility's Behavior Support policy dated September, 2014 was reviewed on 10/30/14 at 11:58 AM and indicated "LifeDesigns believes that all individuals can and should be part of their communities. In accordance with our beliefs, behavior support provided must focus on building the individual's skills and not just eliminating negative behaviors. LifeDesigns will employ only those behavior support techniques, which are the least restrictive and intrusive, support the individual to gain access to the community, and are the most effective for the individual...Life Designs prohibits the use of...anything that inflicts pain or humiliation...." This deficiency was cited on September 12, 2014. The facility failed to implement a systemic plan of correction to prevent reoccurrence. 9-3-5(a)			

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W000289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based upon record review and interview, the facility failed for 1 of 2 sampled clients (client #1), and for 1 additional client (client #3) to ensure their behavior support plans (BSP) included specific information regarding restrictive interventions and a hierarchy for their use. Findings include: 1. Client #1's BSP dated September, 2014 was reviewed on 10/ 28/14 at 6:04 PM. Targeted behaviors included Enuresis/Encopresis (urinating and bowel movements intentionally occurring when not in the bathroom), calling 911, physical aggression (hitting, spitting, touching staff in private areas, throwing objects at others), verbal aggression (name calling, making threats towards others, asking others if he can cause harm	W000289	When providing documents to the surveyor, the Director of Support Services did not provide the most current version of the Behavior Support Plans (several revisions were made over the course of October 2014 due to feedback from staff). The current BSPs in place do in fact include specific holds, as well as a hierarchy for their use, and all staff have been trained on the plans, as well as when to use physical intervention.	12/03/2014

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	to them). The plan indicated "Reactive strategies for verbal aggression indicate that staff should only engage in conversation with [client #1] if he's talking about topics that are calming, and to return to proactive strategies when calm...Reactive strategies for physical aggression state that if [client #1] is physically aggressive and it escalates to a level where he or others appear to be in imminent danger, staff may need to use the appropriate physical intervention technique (CPI) for each unique situation in order to keep [client #1] and staff safe." There was no indication of which CPI (Crisis Prevention Institute) techniques to use or hierarchy for their use. The BSP did not include physical interventions as a reactive strategy for verbal aggression. 2. Client #3's BSP dated September, 2014 was reviewed on 10/29/14 at 8:40 AM. Targeted behaviors indicated physical aggression (pulling shirt off of others), self injurious behavior (rubbing fingers together until they are raw), elopement (climbing out of windows, running away from staff). The plan included the use of Vistaril 25 mg (milligrams) as needed for insomnia and Ativan .5 mg one tablet by mouth every 6 hours as needed for agitation. The plan indicated for physical			

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	aggression "if [client #3] continues to be physically aggressive and it escalates to a level where he or others appear to be in imminent danger, staff may need to use the appropriate physical intervention technique (CPI) for each unique situation in order to keep [client #3] and the staff safe." There was no indication of which CPI techniques to use or hierarchy for their use. The Director of Support Services was interviewed on 11/3/14 at 4:50 PM and indicated the facility used CPI techniques which are taught to all staff. She indicated there were not specific holds or a hierarchy for their use in the clients' plans. 9-3-5(a)			