

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G712	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/11/2011
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 8337 N COLLEGE AVE INDIANAPOLIS, IN46240
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W0000	<p>This visit was for the post certification revisit to the annual recertification and state licensure survey completed on 8/26/11. This survey resulted in an immediate Jeopardy.</p> <p>This visit was done in conjunction with the investigation of complaint #IN00096919.</p> <p>Survey dates: 10/3/11, 10/4/11, 10/5/11, 10/6/11, 10/7/11 and 10/11/11.</p> <p>Facility number: 001089 Provider number: 15G712 AIMS number: 100240060</p> <p>Surveyor: Keith Briner, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/20/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
W0104	<p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and</p>	W0104	The Regional Director spoke with	11/10/2011

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

TITLE

(X6) DATE

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

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	<p>interview for 1 of 4 sampled clients (A), the governing body failed to exercise general policy and operating direction over the facility to ensure the group home had a communication system with the school's transportation department to ensure staff would be present at the group home when client A returned from school early.</p> <p>Findings include:</p> <p>The facility's reportable incident reports were reviewed on 10/3/11 at 3:20 PM. The facility's reportable incident reports indicated the following:</p> <p>-BDDS (Bureau of Developmental Disabilities Services) report dated 9/9/11 indicated on 9/8/11, "When [client A] arrived home from school on the school bus at 3:45 PM there was not a staff present. Staff arrived at 3:50 PM. [Client A] was not harmed or (sic) had no ill effects from this time (sic)."</p> <p>The facility's internal investigation reports were reviewed on 10/4/11 at 9:15 AM. The facility's internal investigation reports indicated the following:</p> <p>-SIR (Summary of Internal Investigation Report) dated 9/12/11 indicated on 9/8/11, "[Client A] arrived home from the school</p>		<p>school administration and notified them that due to safety concerns Client A was moving to a group home in another school district. Regional Director made arrangements for Indiana Mentor staff to provide transportation to and from school. Further communication with the school regarding school bus transportation issues is no longer necessary due to Indiana Mentor providing transportation for Client A. Ongoing, when transportation for consumers is provided by an outside source, the Program Director and/or Home Manager will establish a method for communicating pick up and drop off times to ensure clients are not left unsupervised at any time. At this time no other consumers in the home are transported by outside sources. Responsible Party: Regional Director, Area Director, Program Director, Home manager</p>		

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	<p>bus before staff had arrived home from the [day service] transport...."</p> <p>An interview with QAS #1 (Quality Assurance Specialist) was conducted on 10/4/11 at 10:20 AM. When asked if there was a likelihood of potential harm when client A was left unsupervised if there are transportation communication issues, QAS #1 stated, "yes." When asked if the facility was aware of the incident regarding client A not being monitored after school, QAS #1 stated, "yes." When asked what corrective actions the facility had put in place to ensure continuity of supervision/monitoring, QAS #1 indicated the staffing schedule had been adjusted but no system or plan for communication had been developed between the school and the facility.</p> <p>An interview with PD #1 on 10/4/11 at 10:30 AM was conducted. When asked if there was a likelihood of potential harm when client A is left unsupervised when there are transportation communication issues, PD #1 stated, "yes." When asked if the facility was aware of the incident regarding client A not being monitored after school, PD #1 stated, "yes." indicated the staffing schedule had been adjusted but no system or plan for communication had been developed between the school and the facility.</p>			

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	<p>Client A's record was reviewed on 10/4/11 at 8:31 AM. Client A's ISP (Individual Support Plan) dated 1/26/11 indicated 24 hour supervision is required. Client A's HRC (Human Rights Committee) note dated 9/22/11 indicated, "...[Client A] be placed on one to one staffing during waking hours. On overnight shifts, [client A] will be checked every 15 minutes." The HRC note indicated, "[Client A] will be placed on one to one staffing during waking hours when he arrives home from school until he goes to bed. Staff are to keep [client A] in line of sight during waking hours (with the only exception being when [client A] is showering or using the bathroom staff can remain in the hallway)...." Client A's Risk Management Plan dated 11/26/10 indicated, "[Client A] has a history of elopement and does not exhibit good pedestrian safety skills. [Client A] is to be supervised at all times while out in the community. Staff will direct [client A] to look both ways when crossing the street and use the least restrictive amount of physical assistance needed should he run out into the street. [Client A] is vulnerable to the public and may go with strangers. [Client A] is supervised 24 hours a day by staff. [Client A] is not able to access the community independently...." The review did not</p>			

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W0122	<p>indicate the IDT (Interdisciplinary Team) had met to discuss client A's school transportation incident.</p> <p>Interview with QAS #1 on 10/4/11 at 2:00 PM indicated there were no IDT notes available for review.</p> <p>9-3-1(a)</p> <p>The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 1 of 4 sampled clients (A). The facility failed to implement written policy and procedures to prevent neglect and possible injury to client A. The facility's system for monitoring neglect failed to prevent neglect of client A in regards to ensuring a thorough investigation into the incident. The facility failed to implement written policy and procedures to prevent neglect in regard to implementing effective safeguards to prevent reoccurrence of the client vacating the home.</p> <p>This noncompliance resulted in an Immediate Jeopardy. The Immediate Jeopardy was identified on 10/4/11 at 12:30 PM. The Immediate Jeopardy began on 9/15/11 when the facility failed to</p>	W0122	<p>1. See 149</p> <p>The Program Director will be retrained on investigations to include reporting to the administrator or designee the results within 3 work days. The administrator or designee will review the results of the investigations to ensure a thorough investigation has been submitted. If changes need to be made, Program Director #1 will be required to submit the changes by the 5 th working day. Failure to meet these requirements will result in corrective action. All direct support staff will be retrained on Client A's 1:1 protocol including completing 15 minute checks during the overnight hours. The Area Director had a discussion with the Home Manager at Client A's current residence informing him of the need to ensure staff document the 15 minute checks during overnight hours. The</p>	11/10/2011	

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	<p>implement safeguards to prevent the client from potential injury as a result of exiting a moving vehicle while in motion, running through lanes of traffic on a local roadway, and attempting to enter uninvited/announced into nearby private community residences which resulted in property damage. The Quality Assurance Specialist was notified of the Immediate Jeopardy on 10/4/11 at 12:30 PM regarding the failure of the facility's system to prevent potential injury to client A as a result of his vacating.</p> <p>On 10/5/11 at 4:18 PM the facility submitted the following plan of action to remove the immediate jeopardy: "[Client A's] one to one protocol has been revised and will remain in place, the IDT (Interdisciplinary Team) met on 10/5/11 in regards to the one to one protocol and his BSP (Behavior Support Plan) and how best to keep [client A] safe and avert his vacating behavior which places him in danger. The IDT will continue to meet weekly until [client A's] vacating behavior has ceased and the team feels weekly meetings are no longer necessary. [Client A's] one to one protocol will remain in place until the team determines he is no longer in need of it. [Facility] has requested approval from the State (BDDS placement authority) to have permission to have [client A] 'visit' (sic) at another</p>		<p>Home Manager will complete a thorough review of consumers records including 15 minute checks during the overnight hours a minimum of 3 times per week for 2 months to ensure that all required documentation is present. Indiana Mentor has received a revised Behavior Support Plan for Client A from the behavior consultant which includes recommendations reflected by the HRC on 9/22/11. Client A's IDT has been meeting weekly to discuss Client A's progress and develop additional recommendations as needed. The Home Manager will complete a thorough review of consumers records including Daily Support records, behavior tracking and narrative notes a minimum of 3 times per week for 2 months to ensure that all incidents that fall under the BDDS reportable guidelines are reported to the Program Director within the designated timeframes. After the 2 month period, the HM will complete a thorough review of consumers records including Daily Support records, behavior tracking and narrative notes a minimum of 1 time per week to ensure that all incidents that fall under the BDDS reportable guidelines are reported to the Program Director within the designated timeframes. For 2 months the Program Director will complete a thorough review of consumers records including</p>		

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	group home which is in a safer location for [client A] in regards to his vacating behavior. [Facility] requested this on 10/4/11 and received confirmation from BDDS on 10/5/11 that it is approved for [client A] to move to another group home in a safer location prior to having a new level of care. There PD (Program Director) and HM (Home Manager) of the new group home attended the IDT meeting on 10/5/11 and will receive training on [client A's] BSP and revised one to one protocol. All staff at the new group home will be trained on [client A] and his plans prior to [client A] moving to the new home; (sic) and the one to one will remain in place at the new group home location as well. The team feels that having [client A] visit the new group home on 10/5/11 and 10/6/11 after he arrives home from school until 9 PM would be better for [client A] in terms of transition. [Client A] will spend the afternoon/evening at the new group home on both 10/5/11 and 10/6/11 and return back to his current group home for his 9 PM medications and bed. On 10/7/11 after [client A] returns home form school he will be transported to the new group home and reside there 'visiting' (sic) until a new LOC (sic) is obtained form BDDS and a transition meeting with BDDS occurs to officially admit him to the new group home. Arrangements will be made		Daily Support records, behavior tracking and narrative notes a minimum of 1 time per week to ensure that all incidents that fall under the BDDS reportable guidelines are reported to the Program Director within the designated timeframes. 1. See 153 All direct support staff working at this home were retrained on 10/21/11 on incident reporting requirements including what incidents need to be reported, designated timeframes in which incidents are to be reported and the procedure for immediately notifying the on call supervisor of reportable incidents. The Home Manager will complete a thorough review of consumers records including Daily Support records, behavior tracking and narrative notes a minimum of 3 times per week for 2 months to ensure that all incidents that fall under the BDDS reportable guidelines are reported to the Program Director within the designated timeframes. After the 2 month period, the HM will complete a thorough review of consumers records including Daily Support records, behavior tracking and narrative notes a minimum of 1 time per week to ensure that all incidents that fall under the BDDS reportable guidelines are reported to the Program Director within the designated timeframes. For 2 months the Program Director will complete a thorough review of		

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	to transport [client A] to school at [High School] from the new group home so that his schooling is not affected in this transition/move to a safer location. [Client A's] updated BSP and revised one to one protocol will be implemented on 10/5/11 and any additional HRC (Human Rights Committee) approval will be obtained. All staff in the home will be trained on [client A's] BSP which includes one to one staffing. [Facility] management will develop an observation schedule including the HM, PD, AD (Area Director), RD (Regional Director, and QAS (Quality Assurance Specialist) to monitor that staff are implementing [client A's] BSP and one to one staffing appropriately and effectively. Once the move to the new group home occurs a member of management will visit [client A] at the new home and observe every day for 7 days. after the first 7 days observation will be completed by management a minimum of 4 days per week at the new home. The third week observations will be completed by management a minimum of 3 days per week and the fourth week a minimum of 2 days per week by management. Observations by management will continue at this rate until the team determines routine PD and HM visits are sufficient."		consumers records including Daily Support records, behavior tracking and narrative notes a minimum of 1 time per week to ensure that all incidents that fall under the BDDS reportable guidelines are reported to the Program Director within the designated timeframes. Ongoing, Indiana Mentor management will suspend any staff that may have knowledge of a reportable incident and did not ensure the incident was reported as required. An investigation will be completed. If evidence supports a staff member had knowledge of a reportable incident and did not report it as required, they will receive corrective action up to and including termination. 1. See 154 The Program Director will be retrained on investigations to include reporting to the administrator or designee the results within 3 work days. The administrator or designee will review the results of the investigations to ensure a thorough investigation has been submitted. If changes need to be made Program Director #1 will be required to submit the changes by the 5 th working day. Failure to meet these requirements will result in corrective action. All direct support staff working at this home were retrained on 10/21/11 on incident reporting requirements including what incidents need to be reported,		

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	<p>Through monitoring observations held on 10/5/11 from 5:50 PM through 6:50 PM, 10/6/11 from 6:00 AM through 7:15 AM, 10/7/11 from 6:15 AM through 7:00 AM and 10/11/11 from 5:55 AM through 6:45 AM, the one to one staffing protocol was observed in place. Client A was observed visiting his new group home.</p> <p>Administrative record review of staff training and IDT's indicated training regarding client A's one to one staffing protocol and BSP had occurred with staff. Client A's record was reviewed on 10/7/11 at 10:00 AM and indicated his BSP had been revised to include current supports being implemented. The facility Area Director and Quality Assurance Specialist were notified of the removal of the immediate jeopardy on 10/11/11 at 8:23 AM.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The facility failed to implement written policy and procedures to prevent neglect and possible injury to client A. Please see W149. 2. The facility failed to ensure facility staff and/or the facility reported an allegation of abuse/mistreatment or an injury of unknown origin to the administrator, to the Division of Disability, Aging and Rehabilitative 		<p>designated timeframes in which incidents are to be reported and the procedure for immediately notifying the on call supervisor of reportable incidents. Ongoing, Indiana Mentor management will suspend any staff that may have knowledge of a reportable incident and did not ensure the incident was reported as required. An investigation will be completed. If evidence supports a staff member had knowledge of a reportable incident and did not report it as required, they will receive corrective action up to and including termination.</p> <p>1. See 157</p> <p>All direct support staff will be retrained on Client A's 1:1 protocol including completing 15 minute checks during the overnight hours. The Area Director had a discussion with the Home Manager at Client A's current residence informing him of the need to ensure staff document the 15 minute checks during overnight hours. The Home Manager will complete a thorough review of consumers records including 15 minute checks during the overnight hours a minimum of 3 times per week for 2 months to ensure that all required documentation is present. Indiana Mentor has received a revised Behavior Support Plan for Client A from the behavior consultant which includes recommendations reflected by the HRC on 9/22/11.</p>		

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W0149	<p>Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b) (5) and to Adult Protective Services (APS) per IC 12-10-3 for client A. Please see W153.</p> <p>3. The facility's system for monitoring neglect failed to prevent neglect of client A in regards to ensuring a thorough investigation into the incident. Please see W154.</p> <p>4. The facility failed to implement effective safeguards to prevent reoccurrence of the client A vacating the home. Please see W157.</p> <p>This deficiency was cited on 8/26/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, interview and record review for 1 of 4 sampled clients (A), the facility failed to implement its written policy and procedures regarding abuse/neglect to implement effective</p>	W0149	<p>Client A's IDT has been meeting weekly to discuss Client A's progress and develop additional recommendations as needed. Responsible Party: Home Manager, Program Director, Regional Quality Assurance Specialist, Area Director.</p> <p>All direct support staff working at this home were retrained on 10/21/11 on incident reporting requirements including what incidents need to be reported, designated timeframes in which</p>	11/10/2011	

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	<p>safeguards to prevent potential injury. The facility failed to implement its written policy and procedures regarding abuse/neglect to conduct a thorough investigation in regard to an incident of elopement. The facility failed to implement its written policy and procedures to provide supervision to client A after an incident regarding school transportation. The facility failed to implement its written policy and procedures regarding abuse/neglect to provide continuity of monitoring when client A returns to the group home from school. The facility failed to implement its written policy and procedures regarding abuse/neglect to report an allegation of elopement resulting in property damage to a neighbor's door.</p> <p>Findings include:</p> <p>The facility's reportable incident reports were reviewed on 10/3/11 at 3:20 PM. The facility's reportable incident reports indicated the following:</p> <p>-BDDS (Bureau of Developmental Disabilities Services) report dated 9/16/11 indicated on 9/15/11 at 4:45 PM, "[Client A] eloped from the College group home. [Client A] started running south on College Avenue. PD (Program Director) was able to follow on foot. Staff members</p>		<p>incidents are to be reported and the procedure for immediately notifying the on call supervisor of reportable incidents. Indiana Mentor's current procedures include suspending any staff that may have knowledge of a reportable incident and did not ensure the incident was reported as required. An investigation is then completed. If evidence supports a staff member had knowledge of a reportable incident and did not report it as required, they will receive corrective action up to and including termination. The Program Director will be retrained on investigations to include reporting to the administrator or designee the results within 3 work days. The administrator or designee will review the results of the investigations to ensure a thorough investigation has been submitted. If changes need to be made, Program Director #1 will be required to submit the changes by the 5 th working day. Failure to meet these requirements will result in corrective action. All direct support staff will be retrained on Client A's 1:1 protocol including completing 15 minute checks during the overnight hours. The Area Director had a discussion with the Home Manager at Client A's current residence informing him of the need to ensure staff document the 15 minute checks during overnight hours. The</p>				

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	<p>brought the group home van to assist with bringing [client A] back to the group home. [Client A] returned to the group home on foot with the PD and one staff member." The report indicated the plan to resolve was, "The PD trained staff for [client A] to be put on one to one staffing from the return home from school to bedtime in place. The overnight shift will be completing 15 minute checks." The report did not indicate the use of physical management techniques and the damage that resulted from client A's behavior and/or the proximity of the client to the street with oncoming traffic when the physical management technique was implemented.</p> <p>-BDDS report dated 9/22/11 indicated on 9/21/11, "[Client A] eloped from the group home and ran South on College Avenue. His one to one followed him out of the house. A second staff followed as well. [Client A] was never out of the line of sight of staff. The PD was in the home and got into the group home van and [client A] agreed to get into the van with the PD." The report did not indicate the client vacated the group home van while in motion prior to returning to the group home.</p> <p>-BDDS report dated 9/9/11 indicated on 9/8/11, "When [client A] arrived home</p>		<p>Home Manager will complete a thorough review of consumers records including 15 minute checks during the overnight hours a minimum of 3 times per week for 2 months to ensure that all required documentation is present. Indiana Mentor has received a revised Behavior Support Plan for Client A from the behavior consultant which includes recommendations reflected by the HRC on 9/22/11. Client A's IDT has been meeting weekly to discuss Client A's progress and develop additional recommendations as needed. The Home Manager will complete a thorough review of consumers records including Daily Support records, behavior tracking and narrative notes a minimum of 3 times per week for 2 months to ensure that all incidents that fall under the BDDS reportable guidelines are reported to the Program Director within the designated timeframes. After the 2 month period, the HM will complete a thorough review of consumers records including Daily Support records, behavior tracking and narrative notes a minimum of 1 time per week to ensure that all incidents that fall under the BDDS reportable guidelines are reported to the Program Director within the designated timeframes. For 2 months the Program Director will complete a thorough review of consumers records including</p>		

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	<p>from school on the school bus at 3:45 PM there was not a staff present. Staff arrived at 3:50 PM. [Client A] was not harmed or (sic) had no ill effects from this time (sic)."</p> <p>The facility's internal investigation reports were reviewed on 10/4/11 at 9:15 AM. The facility's internal investigation reports indicated the following:</p> <p>-SIIR (Summary of Internal Investigation Report) dated 9/12/11 indicated on 9/8/11, "[Client A] arrived home from the school bus before staff had arrived home from the [day service] transport...."</p> <p>-SIIR dated 9/20/11 indicated on 9/15/11, "[Client A] eloped from the group home and was not out of sight of the staff members. [Client A] needed transportation back to the group home via the group home van. Staff members followed his BSP (Behavior Support Plan) correctly." The investigation did not indicate timeframe's and/or duration of the elopement, property damage caused by client A, the distance that client A eloped from the group home, include an interview with the PD (Program Director) and/or community participants.</p> <p>-SIIR dated 9/25/11 indicated on 9/21/11, "[Client A] had given me his [department</p>		<p>Daily Support records, behavior tracking and narrative notes a minimum of 1 time per week to ensure that all incidents that fall under the BDDS reportable guidelines are reported to the Program Director within the designated timeframes. Responsible Party: Home Manager, Program Director, Regional Quality Assurance Specialist, Area Director.</p>	

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	store] notes and put on there that we would go Thurs (sic) (today) and I told him that I would be there to take him. When I was leaving he got upset and started throwing things at the wall (actually put a hole in the wall in the living room by the front door). Another staff was blocking the exit into the kitchen. [Client A] ran through the staff blocking the kitchen exit and ran out his bedroom door. The one to one staff followed him, the second staff ran out the front door and I grabbed the keys for the van. I caught up with him in the van at 81st and College and he got in with limited verbal prompting. He did not attempt to get into any houses. He was just jogging along the side of College and was safer this time. When he got into the van he started writing a list for [department store] on a napkin. I explained to him that we were not going to [department store] but that we could go for a drive before we headed back to the group home. Every time that I tried to turn around he yelled, 'No,' so I asked him where he wanted to go. He stated [brand] pizza. I told him that we could drive by [brand] pizza but that we would not be stopping. I told him that we could drive by [client B's] house (client that will be moving in). So we drove by the house and then I turned around and started heading back to the group home on college (sic).			

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	<p>[Client A] jumped out of the moving van and I pulled over. He got 2 magazines out of the free newsstands (sic) and got back into the van before I could even park and get out. When we returned to the home he started doing SIB (Self Injurious Behavior) behavior (sic) (jumping up and body slamming the floor). Staff asked him what he wanted and he would not say. Staff asked him if he was ready to eat pizza and he said yes (sic). He got up off of the floor, washed his hands and sat down for dinner."</p> <p>Citizen A on 10/4/11 at 5:50 PM stated, "Around 4:00 PM on 9/15/11 I saw a big black guy running down College Avenue. I could see from the direction and way that he was running that he was approaching my drive way headed toward my house. I ran out to my garage because the garage door was open and there is a side entry door beside the garage. I was able to lock the side entry door, the black guy and a white female ran into the garage and he started banging on the entry door, trying to get in. When he got in he started running toward the front entry door of the house. I ran to the front door to lock it before he could get in. I was able to get the door locked and he began pounding on the front door, he was yelling and the white female was trying to get him walk away. When he turned around to run away</p>			

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	<p>he knocked over a flower pot that was sitting on the front porch. The flower pot is about 4 foot tall and was retailed at about \$200.00. When the pot hit the concrete it shattered... The black guy then took off running down College Avenue with no shoes on and only wearing a pair of pajama bottoms. I was scared for the client as it was 5:00 PM rush hour traffic on College Avenue, one of the busiest streets in Indianapolis. The guests that I had at my house were also upset and concerned that the client was going to be hit or the white woman chasing him. I watched from my house as more people from the group home got there and they pinned him down on the side of the road. Not in the road but around a foot from the traffic. Someone pulled the van around to try to block traffic but cars were honking their horns and couldn't get around because of oncoming traffic. I was afraid the people were going to get hit so I ran out and started helping. I tried to direct traffic until they got him out of the street. The white woman was trying to get him to take deep breaths and breathe. After about 5 or 10 minutes they got up and started walking him back to the group home. Nobody said anything about the flower pot that he broke so I waited a few minutes then approached the white female and said I know this is not the best time but we need to talk about the flower pot</p>				

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	<p>that he broke. I went back home and later the female came back to my house and introduced herself, I think her name was [PD #1]. She said the company would pay for the flower pot and that she would be back in a few days to discuss the details. My mom purchased another flower pot to replace the one that was broken and it cost \$190.00... The female didn't come back and we haven't heard anything else from the people...." When asked if this was the only incident he had with client A or the group home, citizen A stated this was the only time he had experienced any interaction with the client. Citizen A stated, "A few days before he broke our flower pot he was running around College Avenue and ran up to my neighbor's house. The house was on the market to be sold and so it was empty. He started banging on the front door which was glass. He banged on it so hard it shattered the front door glass." When asked if he recalled the specific date and/or time of the incident, citizen A indicated, "I think it was about 2 days before my flower pot was broken (9/15/11)."</p> <p>Interview with PD #1 on 10/4/11 at 8:25 AM indicated there were no additional BDDS reports and/or internal investigations available for review.</p> <p>Observations were conducted at the group</p>				

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	<p>home on 10/3/11 from 5:15 PM through 6:15 PM. At 5:15 PM client A was laying in his bed with the bedroom door shut. Client A's 1:1 staff was sitting in a chair at the end of the group home hallway located 10 feet away and facing away from client A's bedroom. Staff #1 was not observed in line of sight of client A. At 6:10 PM client A exited his bedroom and joined his peers in the kitchen for evening meal.</p> <p>Interview with QAS #1 (Quality Assurance Specialist) on 10/4/11 at 10:20 AM indicated the investigation regarding the 9/15/11 elopement incident should have included timeframe's and duration of the elopement, property damage caused by client A and the distance that client A eloped from the group home. When asked if the investigation regarding the 9/15/11 incident was thorough, QAS #1 indicated the investigation was not thorough. When asked if there was a likelihood of potential harm when client A runs/walks along College Avenue, attempts to forcibly enter homes in the nearby community, exits the group home van while in motion and/or is left unsupervised when there are transportation communication issues, QAS #1 stated, "yes." When asked if the facility was aware of the incidents of elopement, entering neighboring homes and/or the incident regarding client A not</p>				

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	<p>being monitored after school, QAS #1 stated, "yes." When asked if the corrective actions that had been implemented had been effective in preventing client A from running/walking along College Avenue, attempting to forcibly enter homes in the nearby community, exiting the group home van while in motion and/or is left unsupervised when there are transportation communication issues, QAS #1 stated, "no." When asked if client A is likely to continue running/walking along College Avenue, attempting to forcibly enter homes in the nearby community, exiting the group home van while in motion, QAS #1 stated, "yes."</p> <p>Interview with PD #1 on 10/4/11 at 10:30 AM indicated the investigation regarding the 9/15/11 elopement incident should have included timeframe's and duration of the elopement, property damage caused by client A and the distance that client A eloped from the group home. When asked if the investigation regarding the 9/15/11 incident was thorough, PD #1 indicated the investigation was not thorough. When asked if there was a likelihood of potential harm when client A runs/walks along College Avenue, attempts to forcibly enter homes in the nearby community, exits the group home van while in motion and/or is left unsupervised when there are transportation communication issues, PD</p>			

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	#1 stated, "yes." When asked if the facility was aware of the incidents of elopement, entering neighboring homes and/or the incident regarding client A not being monitored after school, PD #1 stated, "yes." When asked if the corrective actions that had been implemented had been effective in preventing client A from running/walking along College Avenue, attempting to forcibly enter homes in the nearby community, exiting the group home van while in motion and/or is left unsupervised when there are transportation communication issues, PD #1 indicated the facility had started 1:1 staffing to prevent the elopement and started to establish boundaries with a particular staff that client A "obsessed on." When asked if the interventions were effective, PD #1 stated, "no." When asked how staff are to monitor client A while he is in his bedroom, PD #1 indicated staff are to be within line of sight of client A and the bedroom door should be opened to provide visibility. When asked if overnight staff are to monitor and/or document monitoring of client A, PD #1 indicated overnight staff are to conduct and document 15 minute status checks on client A. When asked if client A is likely to continue running/walking along College Avenue, attempting to forcibly enter homes in the nearby community, exiting the group home van while in				

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	<p>motion, PD #1 stated, "yes."</p> <p>The group home's Daily Communication log was reviewed on 10/3/11 at 5:40 PM. Client A's 1:1 monitoring tracking sheet was reviewed. The review indicated the following:</p> <p>-Overnight 15 minute check sheet dated 9/26/11 through 9/27/11 did not indicate checks had been completed from 10:15 PM through 5:15 AM.</p> <p>-Overnight 15 minute check sheet dated 9/27/11 through 9/28/11 did not indicate checks had been completed from 10:15 PM through 5:15 AM.</p> <p>-Overnight 15 minute check sheet dated 10/1/11 through 10/2/11 did not indicate checks had been completed from 10:15 PM through 5:15 AM.</p> <p>-Overnight 15 minute check sheet dated 10/2/11 through 10/3/11 did not indicate checks had been completed from 10:15 PM through 5:15 AM.</p> <p>Interview with PD #2 on 10/3/11 at 5:45 PM indicated staff should be documenting throughout the overnight shift.</p> <p>Client A's record was reviewed on 10/4/11 at 8:31 AM. Client A's ISP</p>				

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	(Individual Support Plan) dated 1/26/11 indicated 24 hour supervision is required. Client A's HRC (Human Rights Committee) note dated 9/22/11 indicated, "...[client A] be placed on 1:1 staffing during waking hours. on overnight shifts, [client A] will be checked every 15 minutes." The HRC note indicated staff are to initial on the provided box after completion of overnight room checks. The HRC note indicated, "[Client A] will be placed on 1:1 staffing during waking hours when he arrives home from school until he goes to bed. Staff are to keep [client A] in line of sight during waking hours (with the only exception being when [client A] is showering or using the bathroom staff can remain in the hallway)...." Client A's Risk Management Plan dated 11/26/10 indicated, "[Client A] has a history of elopement and does not exhibit good pedestrian safety skills. [Client A] is to be supervised at all times while out in the community. Staff will direct [client A] to look both ways when crossing the street and use the least restrictive amount of physical assistance needed should he run out into the street. [Client A] is vulnerable to the public and may go with strangers. [Client A] is supervised 24 hours a day by staff. [Client A] is not able to access the community independently...." The review did not indicate the 4/11 BSP had been updated				

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	and/or revised to reflect the 9/22/11 HRC note changes. The review did not indicate the IDT (Interdisciplinary Team) had met to discuss client A's recent elopement, property destruction incidents and/or the school transportation incident. Client A's BCQR (Behavior Consultant Quarterly Review) form dated 9/21/11 indicated, "I visited [client A's]home on 9/15/11 and spoke with the PD. The PD reported that she would like a BDP (Behavior Development Plan) training completed with staff due to [client A's] vacating and police involvement. The PD reported that the antecedents to the vacating were not clear, that [client A] did not always indicate that he was frustrated or angry, and that when [client A] chose to vacate he was fast and staff had a difficult time catching up to him before he ran to the neighbor's houses or placed himself in potential danger due to the busy road. There was no Behavior Problem Record in place for 9/11/11; however, there was a Narrative Note written for an incident on 9/6/11. [Client A] was at a birthday party. [Client A] started screaming and banging his head on the table... When I saw [client A] on 9/15/11 he appeared to be in a pleasant mood. At one point during the visit I heard a staff member yell [client A's] name and saw them run towards the front door. The PD and I ran towards the front door to see what was going when we			

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	<p>noticed [client A] had vacated the home. [Client A] was was running south through a neighbor's yard. A staff member, the PD and I followed [client A]. [Client A] refused to stop and approached several neighbor's door. he pounded on one neighbor's door and threw another neighbor's flower pot breaking it. At one point the PD had [client A] in arm's length; however, he screamed 'no', pulled away and started running down the street again. [Client A] pounded on car windows on the street and attempted to open a few car doors with no success. Finally we were able to get [client A] on the ground with a physical restraint. Another staff member was contacted, pulled the van up to the side of the road and [client A] was escorted back to the group home...."</p> <p>Interview with QAS #1 on 10/4/11 at 2:00 PM indicated the BSP was in the process of being updated and there were no IDT notes available for review.</p> <p>The facility's policy and procedures were reviewed on 10/4/11 at 7:40 AM The facility's 6/07 policy and procedure entitled Quality Risk Management indicated "Indiana Mentor (parent company) follows the BDDS Incident Reporting policy as outlined in the Providers Standards. An incident</p>						

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W0153	<p>described as follows shall be reported to the BDDS on the incident report from prescribed by BDDS: 1. Alleged, suspected, or actual abuse, neglect, or exploitation of an individual. An incident in this category shall also be reported to adult protective services...." The 6/07 policy and procedure indicated "Indiana Mentor is committed to completing a thorough investigation for any event out of the ordinary which jeopardizes the health and safety of any individual served or other employee." The 6/07 policy and procedure indicated, "Inadequate staff support for an individual, including inadequate supervision, with the potential for significant harm or injury to and individual" was included in the definition of abuse/neglect.</p> <p>This deficiency was cited on 8/26/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on interview and record review for 1 of 3 allegations of abuse/mistreatment</p>	W0153	All direct support staff working at this home were retrained on 10/21/11 on incident reporting	11/10/2011	

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	<p>and/or injury of unknown origin reviewed, the facility failed to ensure facility staff and/or the facility reported an allegation of abuse/mistreatment or an injury of unknown origin to the administrator, to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b) (5) and to Adult Protective Services (APS) per IC 12-10-3 for client A.</p> <p>Findings include:</p> <p>Citizen A on 10/4/11 at 5:50 PM stated, "A few days before he broke our flower pot he was running around College Avenue and ran up to my neighbor's house. The house was on the market to be sold and so it was empty. He started banging on the front door which was glass. He banged on it so hard it shattered the front door glass." When asked if he recalled the specific date and/or time of the incident, citizen A stated, "I think it was about 2 days before my flower pot was broken (9/15/11)."</p> <p>The facility's reportable incident reports were reviewed on 10/3/11 at 3:20 PM. The review did not indicate an incident of elopement and/or property damage to the neighbor's glass door.</p>		<p>requirements including what incidents need to be reported, designated timeframes in which incidents are to be reported and the procedure for immediately notifying the on call supervisor of reportable incidents. The Home Manager will complete a thorough review of consumers records including Daily Support records, behavior tracking and narrative notes a minimum of 3 times per week for 2 months to ensure that all incidents that fall under the BDDS reportable guidelines are reported to the Program Director within the designated timeframes. After the 2 month period, the HM will complete a thorough review of consumers records including Daily Support records, behavior tracking and narrative notes a minimum of 1 time per week to ensure that all incidents that fall under the BDDS reportable guidelines are reported to the Program Director within the designated timeframes. For 2 months the Program Director will complete a thorough review of consumers records including Daily Support records, behavior tracking and narrative notes a minimum of 1 time per week to ensure that all incidents that fall under the BDDS reportable guidelines are reported to the Program Director within the designated timeframes. Ongoing, Indiana Mentor management will suspend any staff that may have knowledge of a reportable</p>				

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W0154	<p>Interview with PD #1 on 10/4/11 at 8:25 AM indicated there were no additional BDDS and/or internal investigations available for review.</p> <p>This deficiency was cited on 8/26/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 2 of 3 allegations of abuse/mistreatment reviewed, the facility failed to conduct an investigation in regards to client A's elopement and property damage incidents.</p> <p>Findings include:</p> <p>The facility's reportable incident reports were reviewed on 10/3/11 at 3:20 PM. The facility's reportable incident reports indicated the following:</p> <p>-BDDS (Bureau of Developmental Disabilities Services) report dated 9/16/11 indicated on 9/15/11 at 4:45 PM, "[Client A] eloped from the College group home. [Client A] started running south on College Avenue. PD (Program Director) was able to follow on foot. Staff members brought the group home van to assist with</p>	W0154	<p>incident and did not ensure the incident was reported as required. An investigation will be completed. If evidence supports a staff member had knowledge of a reportable incident and did not report it as required, they will receive corrective action up to and including termination. Responsible Party: Home Manager, Program Director, Regional Quality Assurance Specialist, Area Director.</p> <p>The Program Director will be retrained on investigations to include reporting to the administrator or designee the results within 3 work days. The administrator or designee will review the results of the investigations to ensure a thorough investigation has been submitted. If changes need to be made Program Director #1 will be required to submit the changes by the 5 th working day. Failure to meet these requirements will result in corrective action.</p> <p>All direct support staff working at this home were retrained on 10/21/11 on incident reporting requirements including what incidents need to be reported, designated timeframes in which incidents are to be reported and the procedure for immediately notifying the on call supervisor of reportable incidents.</p>	11/10/2011			

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	<p>bringing [client A] back to the group home. [Client A] returned to the group home on foot with the PD and one staff member." The report indicated the plan to resolve was, "The PD trained staff for [client A] to be put on 1:1 staffing from the return home from school to bedtime in place. The overnight shift will be completing 15 minute checks." The report did not indicate the use of physical management techniques and/or damage that resulted from client A's behavior and/or the proximity of the client when the physical management technique was implemented by the street with oncoming traffic.</p> <p>The facility's internal investigation reports were reviewed on 10/4/11 at 9:15 AM. The facility's internal investigation reports indicated the following:</p> <p>-SIIR dated 9/20/11 indicated on 9/15/11, "[Client A] eloped from the group home and was not out of sight of the staff members. [Client A] needed transportation back to the group home via the group home van. Staff members followed his BSP (Behavior Support Plan) correctly." The investigation did not indicate timeframes and/or duration of the elopement, property damage caused by client A, the distance that client A eloped from the group home, include an</p>		<p>Ongoing, Indiana Mentor management will suspend any staff that may have knowledge of a reportable incident and did not ensure the incident was reported as required. An investigation will be completed. If evidence supports a staff member had knowledge of a reportable incident and did not report it as required, they will receive corrective action up to and including termination.</p> <p>Responsible Party: Home Manager, Program Director, Regional Quality Assurance Specialist, Area Director.</p>		

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	<p>interview with the PD (Program Director) and/or community participants.</p> <p>The review did not indicate an investigation of the incident of elopement and/or property damage to the neighbor's glass door.</p> <p>Interview with PD #1 on 10/4/11 at 8:25 AM indicated there were no additional BDDS and/or internal investigations available for review.</p> <p>Interview with QAS #1 (Quality Assurance Specialist) on 10/4/11 at 10:20 AM indicated the investigation regarding the 9/15/11 elopement incident should have included timeframe's and/or duration of the elopement, property damage caused by client A and the distance that client A eloped from the group home. When asked if the investigation regarding the 9/15/11 incident was thorough, QAS #1 indicated the investigation was not thorough.</p> <p>Interview with PD #1 on 10/4/11 at 10:30 AM indicated the investigation regarding the 9/15/11 elopement incident should have included timeframes and/or duration of the elopement, property damage caused by client A and the distance that client A eloped from the group home. When asked if the investigation regarding the 9/15/11 incident was thorough, PD #1 indicated</p>			

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W0157	<p>the investigation was not thorough.</p> <p>Citizen A on 10/4/11 at 5:50 PM stated, "A few days before he broke our flower pot he was running around College Avenue and ran up to my neighbor's house. The house was on the market to be sold and so it was empty. He started banging on the front door which was glass. He banged on it so hard it shattered the front door glass." When asked if he recalled the specific date and/or time of the incident, citizen A stated, "I think it was about 2 days before my flower pot was broken (9/15/11)."</p> <p>The review did not indicate an incident of elopement and/or property damage to the neighbor's glass door.</p> <p>This deficiency was cited on 8/26/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview for 2 of 3 allegations of abuse, neglect, mistreatment and injuries of unknown origin reviewed, the facility failed to put in place corrective actions/measures to</p>	W0157	All direct support staff will be retrained on Client A's 1:1 protocol including completing 15 minute checks during the overnight hours. The Area Director had a discussion with the Home Manager at Client A's	11/10/2011	

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	<p>prevent client A from vacating and/or property destruction.</p> <p>Findings include:</p> <p>The facility's reportable incident reports were reviewed on 10/3/11 at 3:20 PM. The facility's reportable incident reports indicated the following:</p> <p>-BDDS (Bureau of Developmental Disabilities Services) report dated 9/16/11 indicated on 9/15/11 at 4:45 PM, "[Client A] eloped from the College group home. [Client A] started running south on College Avenue. PD (Program Director) was able to follow on foot. Staff members brought the group home van to assist with bringing [client A] back to the group home. [Client A] returned to the group home on foot with the PD and one staff member." The report indicated the plan to resolve was, "The PD trained staff for [client A] to be put on 1:1 staffing from the return home from school to bedtime in place. The overnight shift will be completing 15 minute checks." The report did not indicate the use of physical management techniques and/or damage that resulted from client A's behavior and/or the proximity of the client when the physical management technique was implemented by the street with oncoming traffic.</p>		<p>current residence informing him of the need to ensure staff document the 15 minute checks during overnight hours.</p> <p>The Home Manager will complete a thorough review of consumers records including 15 minute checks during the overnight hours a minimum of 3 times per week for 2 months to ensure that all required documentation is present.</p> <p>Indiana Mentor has received a revised Behavior Support Plan for Client A from the behavior consultant which includes recommendations reflected by the HRC on 9/22/11.</p> <p>Client A's IDT has been meeting weekly to discuss Client A's progress and develop additional recommendations as needed.</p> <p>Responsible Party: Home Manager, Program Director, Area Director.</p>		

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	<p>-BDDS report dated 9/22/11 indicated on 9/21/11, "[Client A] eloped from the group home and ran South on College Avenue. His one to one followed him out of the house. A second staff followed as well. [Client A] was never out of the line of sight of staff. The PD was in the home and got into the group home van and [client A] agreed to get into the van with the PD." The report did not indicate the client vacated the group home van while in motion prior to returning to the group home.</p> <p>-BDDS report dated 9/9/11 indicated on 9/8/11, "When [client A] arrived home from school on the school bus at 3:45 PM there was not a staff present. Staff arrived at 3:50 PM. [Client A] was not harmed or (sic) had no ill effects from this time (sic)."</p> <p>QAS #1 (Quality Assurance Specialist) was interviewed on 10/4/11 at 10:20 AM. When asked if the corrective actions that had been implemented had been effective in preventing client A from running/walking along College Avenue, attempting to forcibly enter homes in the nearby community, exiting the group home van while in motion and/or is left unsupervised when there are transportation communication issues,</p>			

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	<p>QAS #1 stated, "no." When asked if client A is likely to continue running/walking along College Avenue, attempting to forcibly enter homes in the nearby community, exiting the group home van while in motion, QAS #1 stated, "yes."</p> <p>On 10/4/11 at 10:30 AM PD #1 was asked if the corrective actions that had been implemented had been effective in preventing client A from running/walking along College Avenue, attempting to forcibly enter homes in the nearby community, exiting the group home van while in motion and/or is left unsupervised when there are transportation communication issues, PD #1 indicated the facility had started 1:1 staffing to prevent the elopement and started to establish boundaries with a particular staff that client A "obsessed on". When asked if the interventions were effective, PD #1 stated, "no." When asked how staff are to monitor client A while he is in his bedroom, PD #1 indicated staff are to be within line of sight of client A and the bedroom door should be opened to provide visibility. When asked if overnight staff are to monitor and/or document monitoring of client A, PD #1 indicated overnight staff are to conduct and document 15 minute status checks on client A. When asked if client A is likely to continue running/walking along</p>				

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	<p>College Avenue, attempting to forcibly enter homes in the nearby community, exiting the group home van while in motion, PD #1 stated, "yes."</p> <p>The group home's Daily Communication log was reviewed on 10/3/11 at 5:40 PM. Client A's 1:1 monitoring tracking sheet was reviewed. The review indicated the following:</p> <p>-Overnight 15 minute check sheet dated 9/26/11 through 9/27/11 did not indicate checks had been completed from 10:15 PM through 5:15 AM.</p> <p>-Overnight 15 minute check sheet dated 9/27/11 through 9/28/11 did not indicate checks had been completed from 10:15 PM through 5:15 AM.</p> <p>-Overnight 15 minute check sheet dated 10/1/11 through 10/2/11 did not indicate checks had been completed from 10:15 PM through 5:15 AM.</p> <p>-Overnight 15 minute check sheet dated 10/2/11 through 10/3/11 did not indicate checks had been completed from 10:15 PM through 5:15 AM.</p> <p>Interview with PD #2 on 10/3/11 at 5:45 PM indicated staff should be documenting throughout the overnight shift.</p>			

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	<p>Client A's record was reviewed on 10/4/11 at 8:31 AM. Client A's ISP (Individual Support Plan) dated 1/26/11 indicated 24 hour supervision is required. Client A's HRC (Human Rights Committee) note dated 9/22/11 indicated, "...[client A] be placed on 1:1 staffing during waking hours. On overnight shifts, [client A] will be checked every 15 minutes." The HRC note indicated staff are to initial on the provided box after completion of overnight room checks. The HRC note indicated, "[Client A] will be placed on 1:1 staffing during waking hours when he arrives home from school until he goes to bed. Staff are to keep [client A] in line of sight during waking hours (with the only exception being when [client A] is showering or using the bathroom staff can remain in the hallway)...." Client A's Risk Management Plan dated 11/26/10 indicated, "[Client A] has a history of elopement and does not exhibit good pedestrian safety skills. [Client A] is to be supervised at all times while out in the community. Staff will direct [client A] to look both ways when crossing the street and use the least restrictive amount of physical assistance needed should he run out into the street. [Client A] is vulnerable to the public and may go with strangers. [Client A] is supervised 24 hours a day by staff. [Client</p>			

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W0256	<p>A] is not able to access the community independently...." The review did not indicate the 4/11 BSP had been updated and/or revised to reflect the 9/22/11 HRC note changes. The review did not indicate the IDT (Interdisciplinary Team) had met to discuss client A's recent elopement, property destruction incidents and/or the school transportation incident.</p> <p>Interview with QAS #1 on 10/4/11 at 2:00 PM indicated the BSP was in the process of being updated and there were no IDT notes available for review. When asked if the facility had met with the school to develop transportation communication policies, QAS #1 indicated she believed the PD had done this but was unable to provide documentation of the meeting and/or the discussion/recommendations.</p> <p>9-3-2(a)</p> <p>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is regressing or losing skills already gained.</p> <p>Based on record review and interview for 1 of 3 sampled clients (A), the QMRP/PD</p>	W0256	Indiana Mentor has received a revised Behavior Support Plan for	11/10/2011	

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	<p>(qualified mental retardation professional/ program director) failed to ensure client A received a behavioral support plan that reflected revisions.</p> <p>Findings include:</p> <p>Client A's record was reviewed on 10/4/11 at 8:31 AM. Client A's HRC (Human Rights Committee) note dated 9/22/11 indicated, "...[client A] be placed on 1:1 staffing during waking hours. On overnight shifts, [client A] will be checked every 15 minutes." The HRC note indicated staff are to initial on the provided box after completion of overnight room checks. The HRC note indicated, "[Client A] will be placed on 1:1 staffing during waking hours when he arrives home from school until he goes to bed. Staff are to keep [client A] in line of sight during waking hours (with the only exception being when [client A] is showering or using the bathroom staff can remain in the hallway)...." The review did not indicate the 4/11 BSP had been updated and/or revised to reflect the 9/22/11 HRC note changes.</p> <p>On 10/4/11 at 10:30 AM PD #1 stated the facility had started 1:1 staffing to prevent the elopement and started to establish boundaries with a particular staff that client A "obsessed on." When asked if the</p>		<p>Client A from the behavior consultant which includes recommendations reflected by the HRC on 9/22/11.</p> <p>Ongoing, when changes to a Behavior Support plan are recommended following a critical incident, such as elopement, the Program Director will request an updated Behavior Support Plan within 5 working days. If the plan is not received within 5 working days the Area Director will contact the Behavior Consultant to inquire as to the status of the plan and when it is expected to be forwarded to the Program Director.</p> <p>Responsible Party: Program Director, Area Director.</p>		

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W9999	<p>interventions were effective, PD #1 stated, "no." When asked how staff are to monitor client A while he is in his bedroom, PD #1 indicated staff are to be within line of sight of client A and the bedroom door should be opened to provide visibility. When asked if overnight staff are to monitor and/or document monitoring of client A, PD #1 indicated overnight staff are to conduct and document 15 minute status checks on client A.</p> <p>Interview with QAS #1 on 10/4/11 at 2:00 PM indicated the BSP was in the process of being updated but was not yet changed to reflect the changes.</p> <p>9-3-4(a)</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rules were not met.</p> <p>1. 431 IAC 1.1-3-1 Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by division.</p>	W9999	<p>All direct support staff working at this home were retrained on 10/21/11 on incident reporting requirements including what incidents need to be reported, designated timeframes in which incidents are to be reported and the procedure for immediately notifying the on call supervisor of reportable incidents.</p> <p>The Home Manager will complete a thorough review of consumers' records including Medication</p>	11/10/2011	

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	<p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 2 of 5 allegations of abuse/mistreatment and/or injury of unknown origin reviewed, the facility failed to report 2 incidents of missed medication doses for clients C and D within 24 hours.</p> <p>Findings include:</p> <p>The facility's reportable incident reports were reviewed on 10/3/11 at 3:20 PM. The facility's reportable incident reports indicated the following:</p> <p>-BDDS (Bureau of Developmental Disabilities) report submitted on 9/27/11 indicated on 9/18/11, "During a medication review, the home manager observed that on 9/18/11 at 5:00 PM, client C did not receive her Gabapentin 500 milligrams (seizures)."</p> <p>-BDDS report submitted on 9/27/11 indicated on 9/18/11, "It was observed during medication review by the home manager, that client D missed his 9/18/11 5:00 PM dose of divalproex tablet 500 milligram (explosive</p>		<p>Administration Records a minimum of 3 times per week for 2 months to ensure that any medication errors that may have occurred have been reported as required.</p> <p>After the 2 month period, the HM will complete a thorough review of consumers records including Medication Administration Records a minimum of 1 time per week to ensure that any medication errors that may have occurred are reported as required.</p> <p>Responsible Party: Home Manager, Program Director, Area Director</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G712	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/11/2011
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	<p>disorder)."</p> <p>Interview with QAS #1 (Quality Assurance Specialist) on 10/4/11 at 1:38 PM indicated all BDDS reportable incidents are supposed to be reported by staff within 24 hours of the incident. QAS #1 indicated missed medication doses are considered BDDS reportable incidents.</p> <p>9-3-1(b)</p>				