

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G418	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5105 N GUION RD INDIANAPOLIS, IN 46254		
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W000000	<p>This visit was for the investigation of complaint #IN00144956.</p> <p>Complaint #IN00144956: Substantiated, federal and state deficiencies related to the allegation(s) are cited at: W102, W104, W120, W122, W149, W154, W156, W157, W159 and W189.</p> <p>Dates of Survey: 3/5/14, 3/6/14, 3/7/14, 3/10/14 and 3/11/14.</p> <p>Facility Number: 000932 Provider Number: 15G418 AIMS Number: 100244560</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/21/14 by Ruth Shackelford, QIDP.</p>	W000000			

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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W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on record review and interview, the facility failed to meet the Condition of Participation: Governing Body for 2 of 4 sampled clients (A and B). The governing body failed to exercise general policy, budgeting and operating direction over the facility to ensure the day program met the needs of client A, to ensure the facility implemented its policy and procedures to prevent neglect of client A regarding elopements, complete an investigation regarding an allegation of neglect for client A, complete thorough investigations of two separate incidents of elopement for client A and one incident of elopement of client B, report the results of an investigation of neglect regarding client A to the administrator within 5 business days and to develop and implement corrective measures to prevent elopement regarding clients A and B, to ensure the QIDP (Qualified Intellectual Disabilities Professional) monitored, coordinated and integrated each client's active treatment program and to ensure staff were trained to work with clients A and B.</p> <p>Findings include:</p>	W000102	<p>1.Please refer to W104 2.Please refer to W122</p>	04/10/2014			

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	<p>1. The governing body failed to exercise general policy, budgeting and operating direction over the facility to ensure the day program met the needs of client A, to ensure the facility implemented its policy and procedures to prevent neglect of client A regarding elopement behavior, complete an investigation regarding an allegation of neglect for client A, complete thorough investigations of two separate incidents of elopement for client A and one incident of elopement of client B, report the results of an investigation of neglect regarding client A to the administrator within 5 business days and develop and implement corrective measures to prevent elopement regarding clients A and B, to ensure the QIDP monitored, coordinated and integrated each client's active treatment program and to ensure staff were trained to work with clients A and B. Please see W104.</p> <p>2. The governing body failed to exercise general policy, budgeting and operating direction over the facility to ensure the facility met the Condition of Participation: Client Protections, to ensure the day program met the needs of client A, to ensure the facility implemented its policy and procedures to prevent neglect of client A regarding elopement behavior, complete an investigation regarding an allegation of</p>						

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	<p>neglect for client A, complete thorough investigations of two separate incidents of elopement for client A and one incident of elopement of client B, report the results of an investigation of neglect regarding client A to the administrator within 5 business days and develop and implement corrective measures to prevent elopement regarding clients A and B, to ensure the QIDP monitored, coordinated and integrated each client's active treatment program and to ensure staff were trained to work with clients A and B. Please see W122.</p> <p>This federal tag relates to complaint #IN00144956.</p> <p>9-3-1(a)</p>				

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W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 2 of 4 sampled clients (A and B), the governing body failed to exercise general policy, budgeting and operating direction over the facility to ensure the day program met the needs of client A, to ensure the facility implemented its policy and procedures to prevent neglect of client A regarding elopement behavior, complete an investigation regarding an allegation of neglect for client A, complete thorough investigations of two separate incidents of elopement for client A and one incident of elopement of client B, report the results of an investigation of neglect regarding client A to the administrator within 5 business days and develop and implement corrective measures to prevent elopement regarding clients A and B, to ensure the QIDP (Qualified Intellectual Disabilities Professional) monitored, coordinated and integrated each client's active treatment program and to ensure staff were trained to work with clients A and B.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy, budgeting and operating</p>	W000104	<p>1. Client A Day service provider has received a copy of Client A Behavior Support Plan. Client A Day Service Provider has received retraining on Client A Behavior Support Plan especially including the procedures for keeping Client A in line of sight supervision and ensuring that staff are monitoring Client A moods and behaviors to monitor for signs that he might elope. Program Director and Home Manager will receive retraining to include ensuring that all Day Service Providers receive retraining on any new or updated Behavior Support Plans for all clients.</p> <p>Ongoing, the Home Manager and/or Program Director will ensure that all Day Service Providers receive copies of all consumers Behavior Support Plans and receive retraining on any new plans or updates to current plans to ensure all recommendations are being implemented. Ongoing the Home Manager and/or Program Director will complete Day Service observations for each client a minimum of every 2 months to ensure that Day Service Providers are implementing Behavior Support Plans as</p>	04/10/2014
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	<p>direction over the facility to ensure the day program met the needs of client A. Please see W120.</p> <p>2. The governing body failed to exercise general policy, budgeting and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of client A regarding elopement behavior, complete an investigation regarding an allegation of neglect for client A, complete thorough investigations of two separate incidents of elopement for client A and one incident of elopement of client B, report the results of an investigation of neglect regarding client A to the administrator within 5 business days and develop and implement corrective measures to prevent elopement regarding clients A and B. Please see W149.</p> <p>3. The governing body failed to exercise general policy, budgeting and operating direction over the facility to ensure the facility conducted an investigation regarding an allegation of neglect for client A, failed to conduct a thorough investigation regarding two separate incidents of elopement for client A and one incident of elopement for client B. Please see W154.</p> <p>3. The governing body failed to exercise</p>		<p>written. Responsible Party: Home Manager, Program Director</p> <p>1. Client A and Client B's supervision levels have been increased at home during waking hours to monitor their interactions to more closely to prevent further incidents of elopement. Staff completes 15 minute checks on Client A and Client B during sleeping hours to monitor to make sure they are not attempting to elope. The Program Director will receive retraining to include ensuring that protective measures are immediately put into place following incidents that involve adverse behaviors that effect or have the potential to affect other consumers in the group home. Program Director will also be responsible for holding IDTs as needed to discuss protective measures and if any updates or changes to the BSPs need to be made. The Program Director and Regional Quality Assurance Specialist will receive retraining on completing thorough investigations including ensuring that all parties related to the incident or could be effected by the incident are interviewed, designating who staff reported injuries and/or allegations to and ensuring all relevant documents, including risk plan, behavior support plans, medical reports, daily support records, etc. are reviewed so that a thorough</p>		

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	<p>general policy, budgeting and operating direction over the facility to ensure the facility reported the results of an allegation of neglect regarding client A's elopement to the facility administrator within 5 business days. Please see W156.</p> <p>4. The governing body failed to exercise general policy, budgeting and operating direction over the facility to ensure to ensure the facility developed and implemented corrective actions to prevent neglect of clients A and B regarding elopement behaviors. Please see W157.</p> <p>5. The governing body failed to exercise general policy, budgeting and operating direction over the facility to ensure the QIDP monitored, coordinated and integrated each client's active treatment program by failing to ensure facility staff were trained to work with clients A and B. Please see W159.</p> <p>6. The governing body failed to exercise general policy, budgeting and operating direction over the facility to ensure staff were trained to work with clients A and B. Please see W189.</p> <p>This federal tag relates to complaint #IN00144956.</p> <p>9-3-1(a)</p>		<p>investigation can be completed. All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made. The Program Director and Regional Quality Assurance Specialist will receive retraining on investigations including reporting to the administrator or designee the results within 5 work days and also ensuring that all parties related to the incident are interviewed so that a thorough investigation can be completed. All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary</p>		

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			<p>changes will be made.</p> <p>Client A and Client B Behavior Support Plans have been updated to include addressing elopement behaviors, line of sight supervision, staff interventions for preventing elopement from the home and procedures for what to do if Client A or B elopes from the home.</p> <p>All Direct Care staff will receive retraining to include a review of Client A and B's ISP, RMAP and also updated Behavior Support Plans which include addressing elopement behaviors, line of sight supervision, staff interventions for preventing elopement from the home and procedures for what to do if Client A or B elopes from the home.</p> <p>Program Director will receive retraining to include ensuring that all Direct Care staff are trained on all consumers initial and updated Behavior Support Plans once complete so they are aware of which steps to use to monitor and prevent targeted consumer behaviors and which interventions to use if targeted behaviors occur. Ongoing the Program Director will ensure that all staff are trained on any initial and updated Behavior Support Plans once complete so they are aware of which steps to use to monitor and prevent targeted consumer behaviors and which interventions to use if targeted behaviors occur. The Program Director will provide the Area Director will copies of the</p>	

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			<p>staff training once complete to ensure all staff are trained on BSP updates.</p> <p>Client A Day service provider has received a copy of Client A Behavior Support Plan. Client A Day Service Provider has received retraining on Client A Behavior Support Plan especially including the procedures for keeping Client A in line of sight supervision and ensuring that staff are monitoring Client A moods and behaviors to monitor for signs that he might elope. Program Director and Home Manager will receive retraining to include ensuring that all Day Service Providers receive retraining on any new or updated Behavior Support Plans for all clients.</p> <p>Ongoing, the Home Manager and/or Program Director will ensure that all Day Service Providers receive copies of all consumers Behavior Support Plans and receive retraining on any new plans or updates to current plans to ensure all recommendations are being implemented. Ongoing the Home Manager and/or Program Director will complete Day Service observations for each client a minimum of every 2 months to ensure that Day Service Providers are implementing Behavior Support Plans as written.</p> <p>The Program Director will receive retraining to include ensuring that</p>	

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			<p>when targeted behavior such as elopement occurs an investigation is completed to assess if staff followed consumers Behavior Support Plan interventions as directed. Based on the results of the investigation the Program Director will develop recommendation as needed regarding prevention of future targeted behaviors.</p> <p>The Program Director will receive retraining on the need to ensure Interdisciplinary Team meetings are held as needed for consumers once incidents of targeted behaviors, such as elopements, occur to determine if staff followed consumers Behavior Support Plans as directed and determine if other protective measures need to be put into place or if any changes need to be made to consumers Behavior Support Plans.</p> <p>Ongoing, the Program Director will ensure that Interdisciplinary Team meetings are held as needed for consumers once incidents of targeted behaviors, such as elopements, occur to determine if staff followed consumers Behavior Support Plans as directed and determine if other protective measures need to be put into place or if any changes need to be made to consumers Behavior Support Plans.</p>		

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			<p>Responsible Party: Home Manager, Program Director, Behavior Specialist, Day Service staff, Area Director</p> <p>1.The Program Director and Quality Assurance Specialist will receive retraining on ensuring that investigations are completed for any incidents that may indicate potential abuse, neglect or mistreatment of clients has occurred.</p> <p>The Program Director and Quality Assurance Specialist will receive retraining on investigations including reporting to the administrator or designee the results within 5 work days and also ensuring that all parties related to the incident are interviewed so that a thorough investigation can be completed. The Area Director will track all incidents for which ones require an investigation. If an incident requires an investigation, the Area Director will track that investigations are being completed and being completed within the 5 business day guidelines. As it is getting close to the 5 day mark, if the Area Director has not received a required investigation, the Area Director will provide feedback to the Program Director and/or the Quality Assurance Specialist to inquire as to the status of the investigation.</p> <p>All future incident reports will be reviewed by the Area Director and</p>		

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			<p>Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made.</p> <p>Responsible Party: Program Director, Regional Quality Assurance Specialist, Area Director.</p> <p>1. The Program Director and Quality Assurance Specialist will receive retraining on investigations including reporting to the administrator or designee the results within 5 work days and also ensuring that all parties related to the incident are interviewed so that a thorough investigation can be completed.</p> <p>All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide</p>		

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			<p>immediate feedback to the Program Director and necessary changes will be made.</p> <p>Responsible Party: Home Manager, Program Director, Regional Quality Assurance Specialist, Area Director.</p> <p>5,6,7 Client A and Client B Behavior Support Plans have been updated to include addressing elopement behaviors, line of sight supervision, staff interventions for preventing elopement from the home and procedures for what to do if Client A or B elopes from the home. All Direct Care staff will receive retraining to include a review of Client A and B's ISP, RMAP and also updated Behavior Support Plans which include addressing elopement behaviors, line of sight supervision, staff interventions for preventing elopement from the home and procedures for what to do if Client A or B elopes from the home. Program Director will receive retraining to include ensuring that all Direct Care staff are trained on all consumers initial and updated Behavior Support Plans once complete so they are aware of which steps to use to monitor and prevent targeted consumer behaviors and which interventions to use if targeted behaviors occur. Ongoing the Program Director will ensure that all staff are trained on any initial and updated Behavior</p>		

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			<p>Support Plans once complete so they are aware of which steps to use to monitor and prevent targeted consumer behaviors and which interventions to use if targeted behaviors occur. The Program Director will provide the Area Director will copies of the staff training once complete to ensure all staff are trained on BSP updates.</p> <p>Client A Day service provider has received a copy of Client A Behavior Support Plan. Client A Day Service Provider has received retraining on Client A Behavior Support Plan especially including the procedures for keeping Client A in line of sight supervision and ensuring that staff are monitoring Client A moods and behaviors to monitor for signs that he might elope. Program Director and Home Manager will receive retraining to include ensuring that all Day Service Providers receive retraining on any new or updated Behavior Support Plans for all clients.</p> <p>Ongoing, the Home Manager and/or Program Director will ensure that all Day Service Providers receive copies of all consumers Behavior Support Plans and receive retraining on any new plans or updates to current plans to ensure all recommendations are being implemented. Ongoing the Home Manager and/or Program Director will complete Day Service</p>	

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			<p>observations for each client a minimum of every 2 months to ensure that Day Service Providers are implementing Behavior Support Plans as written.</p> <p>The Program Director will receive retraining to include ensuring that when targeted behavior such as elopement occurs an investigation is completed to assess if staff followed consumers Behavior Support Plan interventions as directed. Based on the results of the investigation the Program Director will develop recommendation as needed regarding prevention of future targeted behaviors.</p> <p>The Program Director will receive retraining on the need to ensure Interdisciplinary Team meetings are held as needed for consumers once incidents of targeted behaviors, such as elopements, occur to determine if staff followed consumers Behavior Support Plans as directed and determine if other protective measures need to be put into place or if any changes need to be made to consumers Behavior Support Plans.</p> <p>Ongoing, the Program Director will ensure that Interdisciplinary Team meetings are held as needed for consumers once incidents of targeted behaviors, such as elopements, occur to determine if staff followed</p>		

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			<p>consumers Behavior Support Plans as directed and determine if other protective measures need to be put into place or if any changes need to be made to consumers Behavior Support Plans.</p> <p>Responsible Party: Home Manager, Program Director, Behavior Specialist, Day Service staff, Area Director</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G418	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/11/2014
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W000120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. Based on record review and interview for 1 of 4 sampled clients (A), the facility failed to ensure the day program met the needs of client A.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services Reports) and investigations were reviewed on 3/5/14 at 2:30 PM. The review indicated the following:</p> <p>-BDDS report dated 2/19/14, 11:15 AM indicated, "[Client A] reported to his supervisor that he was not feeling well. [Client A] reported that he had an upset stomach and staff discussed to find that he was reporting that it was due to noise. Staff discussed and [client A] wanted to go outside. Staff walked outside with [client A] then went to call his residential staff to discuss. [Day service] staff called [RM #1 (Residential Manager)] and left a message immediately returning to where [client A] was. [Client A] was no longer there and staff began an immediate search of the area. [Client A] could not be found so staff began to search the neighborhood and called residential provider back.</p>	W000120	<p>Client A Day service provider has received a copy of Client A Behavior Support Plan. Client A Day Service Provider has received retraining on Client A Behavior Support Plan especially including the procedures for keeping Client A in line of sight supervision and ensuring that staff are monitoring Client A moods and behaviors to monitor for signs that he might elope. Program Director and Home Manager will receive retraining to include ensuring that all Day Service Providers receive retraining on any new or updated Behavior Support Plans for all clients. Ongoing, the Home Manager and/or Program Director will ensure that all Day Service Providers receive copies of all consumers Behavior Support Plans and receive retraining on any new plans or updates to current plans to ensure all recommendations are being implemented. Ongoing the Home Manager and/or Program Director will complete Day Service observations for each client a minimum of every 2 months to ensure that Day Service Providers are implementing Behavior Support Plans as written.</p>	04/10/2014
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	<p>Residential staff discovered that [client A] was at the [community] library and went to pick him up at approximately 1:00 PM. Plan to resolve: Team will meet to discuss appropriate safety parameters." The 2/19/14 BDDS report indicated client A was out of supervision from 11:15 AM through 1:00 PM. The 2/19/14 BDDS report indicated day service staff left client A outside unattended.</p> <p>-Summary of Internal Investigation Report (SIIR) dated 2/26/14 regarding client A's 2/19/14 elopement indicated day program staff had allowed client A to go outside while at the day program unattended. The 2/26/14 SIIR interview with DPM (Day Program Manager) #1 indicated "... said he forgot that [client A] was an elopement risk."</p> <p>-Recommendations resulting from an Investigation (RRI) form dated 2/20/14 included the following recommendations regarding client A's 2/29/14 elopement "Ensure day program has a copy and are trained on [client A's] BSP (Behavior Support Plan)...."</p> <p>Client A's record was reviewed on 3/6/14 at 11:06 AM. Client A's BSP dated 1/20/14 indicated the following:</p>		Responsible Party: Home Manager, Program Director				

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	<p>-"Due to the frequent attempts to elope/vacate, [client A] is to remain in a 'line of sight' perimeter at all times during waking hours."</p> <p>-"The staff should pay special attention to [client A's] mood and behavior. If the staff member suspects [client A] is getting agitated and his behavior may escalate, attempt to redirect [client A] to an activity in an area... that does not have direct access to outside.... The one-on-one staff should also pay special attention to [client A] when he is near any door leading to the outside.... The staff should always be closest to the door when in a room with [client A]."</p> <p>AD (Area Director) #1 was interviewed on 3/6/14 at 12:01 PM. AD #1 indicated there was not documentation of client A's day program receiving client A's BSP. AD #1 indicated client A's day program had not been trained regarding client A's BSP. AD #1 stated, "We would normally train one of the day staff and then the day staff would train the team."</p> <p>This federal tag relates to complaint #IN00144956.</p> <p>9-3-1(a)</p>						

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W000122	<p>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 for 2 of 4 sampled clients (A and B). The facility failed to implement its policy and procedures to prevent neglect of client A regarding elopement behavior, complete an investigation regarding an allegation of neglect for client A, complete thorough investigations of two separate incidents of elopement for client A and one incident of elopement of client B, report the results of an investigation of neglect regarding client A to the administrator within 5 business days and develop and implement corrective measures to prevent elopement regarding clients A and B.</p> <p>Findings include:</p> <p>1. The facility failed to implement its policy and procedures to prevent neglect of client A regarding elopement behavior, complete an investigation regarding an allegation of neglect for client A, complete thorough investigations of two separate incidents of elopement for client A and one incident of elopement of client B, report the results of an investigation of neglect regarding client A to the administrator within 5 business days and</p>	W000122	<p>1. Client A and Client B's supervision levels have been increased at home during waking hours to monitor their interactions to more closely to prevent further incidents of elopement. Staff completes 15 minute checks on Client A and Client B during sleeping hours to monitor to make sure they are not attempting to elope. The Program Director will receive retraining to include ensuring that protective measures are immediately put into place following incidents that involve adverse behaviors that effect or have the potential to affect other consumers in the group home. Program Director will also be responsible for holding IDTs as needed to discuss protective measures and if any updates or changes to the BSPs need to be made. The Program Director and Regional Quality Assurance Specialist will receive retraining on completing thorough investigations including ensuring that all parties related to the incident or could be effected by the incident are interviewed, designating who staff reported injuries and/or allegations to and ensuring all relevant documents, including risk plan, behavior support plans, medical reports, daily support records, etc. are</p>	04/10/2014			

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	<p>develop and implement corrective measures to prevent elopement regarding clients A and B. Please see W149.</p> <p>2. The facility failed to conduct an investigation regarding an allegation of neglect for client A, failed to conduct a thorough investigation regarding two separate incidents of elopement for client A and one incident of elopement for client B. Please see W154.</p> <p>3. The facility failed to report the results of an allegation of neglect regarding client A's elopement to the facility administrator within 5 business days. Please see W156.</p> <p>4. The facility failed to develop and implement corrective actions to prevent neglect of clients A and B regarding elopement behaviors. Please see W157.</p> <p>This federal tag relates to complaint #IN00144956.</p> <p>9-3-2(a)</p>		<p>reviewed so that a thorough investigation can be completed. All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made. The Program Director and Regional Quality Assurance Specialist will receive retraining on investigations including reporting to the administrator or designee the results within 5 work days and also ensuring that all parties related to the incident are interviewed so that a thorough investigation can be completed. All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the</p>		

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			<p>Program Director and necessary changes will be made.</p> <p>Client A and Client B Behavior Support Plans have been updated to include addressing elopement behaviors, line of sight supervision, staff interventions for preventing elopement from the home and procedures for what to do if Client A or B elopes from the home.</p> <p>All Direct Care staff will receive retraining to include a review of Client A and B's ISP, RMAP and also updated Behavior Support Plans which include addressing elopement behaviors, line of sight supervision, staff interventions for preventing elopement from the home and procedures for what to do if Client A or B elopes from the home.</p> <p>Program Director will receive retraining to include ensuring that all Direct Care staff are trained on all consumers initial and updated Behavior Support Plans once complete so they are aware of which steps to use to monitor and prevent targeted consumer behaviors and which interventions to use if targeted behaviors occur. Ongoing the Program Director will ensure that all staff are trained on any initial and updated Behavior Support Plans once complete so they are aware of which steps to use to monitor and prevent targeted consumer behaviors and which interventions to use if targeted behaviors occur. The Program Director will provide the</p>	

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			<p>Area Director will copies of the staff training once complete to ensure all staff are trained on BSP updates.</p> <p>Client A Day service provider has received a copy of Client A Behavior Support Plan. Client A Day Service Provider has received retraining on Client A Behavior Support Plan especially including the procedures for keeping Client A in line of sight supervision and ensuring that staff are monitoring Client A moods and behaviors to monitor for signs that he might elope. Program Director and Home Manager will receive retraining to include ensuring that all Day Service Providers receive retraining on any new or updated Behavior Support Plans for all clients.</p> <p>Ongoing, the Home Manager and/or Program Director will ensure that all Day Service Providers receive copies of all consumers Behavior Support Plans and receive retraining on any new plans or updates to current plans to ensure all recommendations are being implemented. Ongoing the Home Manager and/or Program Director will complete Day Service observations for each client a minimum of every 2 months to ensure that Day Service Providers are implementing Behavior Support Plans as written.</p> <p>The Program Director will receive</p>	

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			<p>retraining to include ensuring that when targeted behavior such as elopement occurs an investigation is completed to assess if staff followed consumers Behavior Support Plan interventions as directed. Based on the results of the investigation the Program Director will develop recommendation as needed regarding prevention of future targeted behaviors.</p> <p>The Program Director will receive retraining on the need to ensure Interdisciplinary Team meetings are held as needed for consumers once incidents of targeted behaviors, such as elopements, occur to determine if staff followed consumers Behavior Support Plans as directed and determine if other protective measures need to be put into place or if any changes need to be made to consumers Behavior Support Plans. Ongoing, the Program Director will ensure that Interdisciplinary Team meetings are held as needed for consumers once incidents of targeted behaviors, such as elopements, occur to determine if staff followed consumers Behavior Support Plans as directed and determine if other protective measures need to be put into place or if any changes need to be made to consumers Behavior Support Plans.</p>	

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			<p>Responsible Party: Home Manager, Program Director, Behavior Specialist, Day Service staff, Area Director</p> <p>1.The Program Director and Quality Assurance Specialist will receive retraining on ensuring that investigations are completed for any incidents that may indicate potential abuse, neglect or mistreatment of clients has occurred.</p> <p>The Program Director and Quality Assurance Specialist will receive retraining on investigations including reporting to the administrator or designee the results within 5 work days and also ensuring that all parties related to the incident are interviewed so that a thorough investigation can be completed. The Area Director will track all incidents for which ones require an investigation. If an incident requires an investigation, the Area Director will track that investigations are being completed and being completed within the 5 business day guidelines. As it is getting close to the 5 day mark, if the Area Director has not received a required investigation, the Area Director will provide feedback to the Program Director and/or the Quality Assurance Specialist to inquire as to the status of the investigation.</p> <p>All future incident reports will be reviewed by the Area Director and</p>		

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			<p>Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made. Responsible Party: Program Director, Regional Quality Assurance Specialist, Area Director.</p> <p>1. The Program Director and Quality Assurance Specialist will receive retraining on investigations including reporting to the administrator or designee the results within 5 work days and also ensuring that all parties related to the incident are interviewed so that a thorough investigation can be completed.</p> <p>All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality</p>		

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			<p>Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made.</p> <p>Responsible Party: Home Manager, Program Director, Regional Quality Assurance Specialist, Area Director.</p> <p>1. Client A and Client B Behavior Support Plans have been updated to include addressing elopement behaviors, line of sight supervision, staff interventions for preventing elopement from the home and procedures for what to do if Client A or B elopes from the home.</p> <p>All Direct Care staff will receive retraining to include a review of Client A and B's ISP, RMAP and also updated Behavior Support Plans which include addressing elopement behaviors, line of sight supervision, staff interventions for preventing elopement from the home and procedures for what to do if Client A or B elopes from the home.</p> <p>Program Director will receive retraining to include ensuring that all Direct Care staff are trained on all consumers initial and updated Behavior Support Plans once complete so they are aware of which steps to use to monitor and prevent targeted consumer behaviors and which interventions to use if targeted behaviors occur. Ongoing the Program Director will ensure that all staff are trained on</p>		

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			<p>any initial and updated Behavior Support Plans once complete so they are aware of which steps to use to monitor and prevent targeted consumer behaviors and which interventions to use if targeted behaviors occur. The Program Director will provide the Area Director will copies of the staff training once complete to ensure all staff are trained on BSP updates.</p> <p>Client A Day service provider has received a copy of Client A Behavior Support Plan. Client A Day Service Provider has received retraining on Client A Behavior Support Plan especially including the procedures for keeping Client A in line of sight supervision and ensuring that staff are monitoring Client A moods and behaviors to monitor for signs that he might elope. Program Director and Home Manager will receive retraining to include ensuring that all Day Service Providers receive retraining on any new or updated Behavior Support Plans for all clients.</p> <p>Ongoing, the Home Manager and/or Program Director will ensure that all Day Service Providers receive copies of all consumers Behavior Support Plans and receive retraining on any new plans or updates to current plans to ensure all recommendations are being implemented. Ongoing the Home Manager and/or Program Director</p>		

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			<p>will complete Day Service observations for each client a minimum of every 2 months to ensure that Day Service Providers are implementing Behavior Support Plans as written.</p> <p>The Program Director will receive retraining to include ensuring that when targeted behavior such as elopement occurs an investigation is completed to assess if staff followed consumers Behavior Support Plan interventions as directed. Based on the results of the investigation the Program Director will develop recommendation as needed regarding prevention of future targeted behaviors.</p> <p>The Program Director will receive retraining on the need to ensure Interdisciplinary Team meetings are held as needed for consumers once incidents of targeted behaviors, such as elopements, occur to determine if staff followed consumers Behavior Support Plans as directed and determine if other protective measures need to be put into place or if any changes need to be made to consumers Behavior Support Plans.</p> <p>Ongoing, the Program Director will ensure that Interdisciplinary Team meetings are held as needed for consumers once incidents of targeted behaviors,</p>		

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			such as elopements, occur to determine if staff followed consumers Behavior Support Plans as directed and determine if other protective measures need to be put into place or if any changes need to be made to consumers Behavior Support Plans. Responsible Party: Home Manager, Program Director, Behavior Specialist, Day Service staff, Area Director	

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 6 of 15 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to implement its policy and procedures to prevent neglect of client A regarding elopement behavior, complete an investigation regarding an allegation of neglect for client A, complete thorough investigations of two separate incidents of elopement for client A and one incident of elopement of client B, report the results of an investigation of neglect regarding client A to the administrator within 5 business days and develop and implement corrective measures to prevent elopement regarding clients A and B.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services Reports) and investigations were reviewed on 3/5/14 at 2:30 PM. The review indicated the following:</p> <p>1. BDDS report dated 1/10/14 indicated, "[Client A] wanted to go to the gas station to purchase some snacks. Staff asked [client A] to wait until schedule(d)</p>	W000149	Client A and Client B's supervision levels have been increased at home during waking hours to monitor their interactions to more closely to prevent further incidents of elopement. Staff completes 15 minute checks on Client A and Client B during sleeping hours to monitor to make sure they are not attempting to elope. The Program Director will receive retraining to include ensuring that protective measures are immediately put into place following incidents that involve adverse behaviors that effect or have the potential to affect other consumers in the group home. Program Director will also be responsible for holding IDTs as needed to discuss protective measures and if any updates or changes to the BSPs need to be made. The Program Director and Regional Quality Assurance Specialist will receive retraining on completing thorough investigations including ensuring that all parties related to the incident or could be effected by the incident are interviewed, designating who staff reported injuries and/or allegations to and ensuring all relevant documents, including risk plan, behavior support plans, medical reports, daily support records, etc. are	04/10/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G418		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014	
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	<p>activities were completed to go. [Client A] went to his room and staff continued with group home activity. Staff went to [client A's] room to get him for medication pass and discovered [client A] had eloped from group home. Staff noticed (sic) [HM #1 (Home Manager)] and [HM #1] instructed staff to notify the police. Police came to the group house (sic) 30 minutes after initial call to inform staff that [client A] was located and taken to [hospital] for further evaluation. Plan to resolve: [Client A] was evaluated by hospital staff and was released back to group home. [Client A] was placed on line of sight supervision protocol until IDT (Interdisciplinary Team) meeting is able to meet to discuss [client A's] health and safety. Staff was suspended pending investigation."</p> <p>-Police report dated 1/9/14 at 8:44 PM indicated, "On 1/9/14 at 1751 hours (5:51 PM), [officer #1], was dispatched to the 4800 block of [street] to investigate a report of a teenage BM (Black Male) wearing only a brown t-shirt, blue jeans with no shoes or coat walking south on [street]. The above run was initiated at 1748 hours (5:48 PM) and officers located the above individual in the 4400 block of [street] at 1759 hours (5:59 PM) walking south bound on [street]. After locating the above individual, later</p>		<p>reviewed so that a thorough investigation can be completed. All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made. The Program Director and Regional Quality Assurance Specialist will receive retraining on investigations including reporting to the administrator or designee the results within 5 work days and also ensuring that all parties related to the incident are interviewed so that a thorough investigation can be completed. All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the</p>				

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	identified as [client A], I was able to observe that he was only wearing a t-shirt and jeans and had his shoulder hunched upwards with his hands out which appeared as if [client A] was very cold. I activated my overhead lights and [client A] turned to look and stopped. I approached [client A] and asked his name and where he lived. [Client A] provided me his name which I was later able to verify was accurate. [Client A] stated that he lived in [neighborhood] on [address] and stated that he did not know how he got to where he currently was. I was able to observe that [client A] was not wearing any shoes and that his socks were completely soaked as he had been walking in the slush on the side of the road. I placed [client A] in the back of my police vehicle to help him warm up and called for a medic to provide a checkout of [client A] due to the fact that the temperature was very cold combined with the lack of clothing that he was wearing. [Medic] arrived on scene and stated that it was possible that [client A] was hypothermic. I conducted a search of [client A] through case request and found that [client A] had been placed under immediate detention in the past and that he was autistic. I attempted to make contact with [client A's] mother from telephone numbers from past reports with no success. Due to the fact that officers		Program Director and necessary changes will be made. Client A and Client B Behavior Support Plans have been updated to include addressing elopement behaviors, line of sight supervision, staff interventions for preventing elopement from the home and procedures for what to do if Client A or B elopes from the home. All Direct Care staff will receive retraining to include a review of Client A and B's ISP, RMAP and also updated Behavior Support Plans which include addressing elopement behaviors, line of sight supervision, staff interventions for preventing elopement from the home and procedures for what to do if Client A or B elopes from the home. Program Director will receive retraining to include ensuring that all Direct Care staff are trained on all consumers initial and updated Behavior Support Plans once complete so they are aware of which steps to use to monitor and prevent targeted consumer behaviors and which interventions to use if targeted behaviors occur. Ongoing the Program Director will ensure that all staff are trained on any initial and updated Behavior Support Plans once complete so they are aware of which steps to use to monitor and prevent targeted consumer behaviors and which interventions to use if targeted behaviors occur. The Program Director will provide the		

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	<p>were unable to confirm where [client A] was currently living, how he arrived at the location where he was found by officers along with the fact that [client A] was walking on a busy, snow covered street during rush hour traffic in very cold temperatures with no coat or shoes, officers placed [client A] under immediate detention. [Client A] was transported by [ambulance] to [hospital].</p> <p>At 2044 hours (8:44 PM), on 1/9/14, [officer #1] and [officer #2], received a radio dispatched run to [group home] on a missing person. 911 caller stated to dispatchers that a BM, who is the above individual, was last seen five minutes ago from the time of the 911 call walking out the door. Officers cleared the run and control operations confirmed that [client A] was still currently at [hospital]. Upon my arrival on scene at [group home] I spoke with [staff #1] (sic) stated that [client A] had last been seen about five minutes prior to the 911 call and that she did not know where he was. [Staff #1] and the rest of the staff were not aware that [client A] had been transported to the hospital several hours prior to them finally realizing that he was missing. [Staff #1] stated that she was serving the snack and that she yelled for [client A] to come eat and was unable to locate him. [Staff #1] stated that earlier in the day at</p>		<p>Area Director will copies of the staff training once complete to ensure all staff are trained on BSP updates.</p> <p>Client A Day service provider has received a copy of Client A Behavior Support Plan. Client A Day Service Provider has received retraining on Client A Behavior Support Plan especially including the procedures for keeping Client A in line of sight supervision and ensuring that staff are monitoring Client A moods and behaviors to monitor for signs that he might elope. Program Director and Home Manager will receive retraining to include ensuring that all Day Service Providers receive retraining on any new or updated Behavior Support Plans for all clients.</p> <p>Ongoing, the Home Manager and/or Program Director will ensure that all Day Service Providers receive copies of all consumers Behavior Support Plans and receive retraining on any new plans or updates to current plans to ensure all recommendations are being implemented. Ongoing the Home Manager and/or Program Director will complete Day Service observations for each client a minimum of every 2 months to ensure that Day Service Providers are implementing Behavior Support Plans as written.</p> <p>The Program Director will receive</p>	

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	<p>what she said was about 1700 hours (5:00 PM), [client A] had left the house and made it to the end of the driveway before staff were able to bring him back inside. [Staff #1] stated that once inside [staff #2] took [client A's] shoes and coat to prevent [client A] from exiting the house again. [Staff #1] would later state that other staff members may have realized [client A] was missing prior to snack time when they give the residents there (sic) medication usually between 2030 hours and 2045 hours. [Staff #1] stated that after they had brought [client A] back inside after the first time he left, she had set the door alarms which she stated alerts the staff that a door had been opened. I went to three separate doors in the house and opened each one. On each door, when it was opened, no alarm sounded. [Staff #1] was able to get the door alarm to work and when the alarm sounded it was so faint that it could only be heard from the living room. I then spoke with [staff #2] about the incident, [staff #2], stated to officers that he last saw [client A] at around 1900 hours and that he realized that [client A] was missing when he was giving the residents there (sic) medication at about 2000 hours (8:00 PM). [Staff #2] stated that he then left the house to go look for [client A]. I advised house staff that [client A] had been located by officers</p>		<p>retraining to include ensuring that when targeted behavior such as elopement occurs an investigation is completed to assess if staff followed consumers Behavior Support Plan interventions as directed. Based on the results of the investigation the Program Director will develop recommendation as needed regarding prevention of future targeted behaviors.</p> <p>The Program Director will receive retraining on the need to ensure Interdisciplinary Team meetings are held as needed for consumers once incidents of targeted behaviors, such as elopements, occur to determine if staff followed consumers Behavior Support Plans as directed and determine if other protective measures need to be put into place or if any changes need to be made to consumers Behavior Support Plans.</p> <p>Ongoing, the Program Director will ensure that Interdisciplinary Team meetings are held as needed for consumers once incidents of targeted behaviors, such as elopements, occur to determine if staff followed consumers Behavior Support Plans as directed and determine if other protective measures need to be put into place or if any changes need to be made to consumers Behavior Support</p>	

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	<p>approximately a half a mile down the road walking in the road with no shoes or coat at about 1759 (5:59 PM). I also advised the staff that [client A] was currently at [hospital] under immediate detention and receiving medical attention for being in the cold for a period of time without proper attire. Over the past year officers have responded to this group home numerous times to assist in locating special needs residents who have left the house. Due to the fact that [client A], a special needs resident who at the time was under the direct supervision and care of the group home staff was able to exit the house into poor weather conditions for several hours prior to group home staff realizing he was gone (sic)."</p> <p>-Summary of Internal Investigation Report (SIIR) dated 1/22/14 regarding client A's 1/9/14 elopement from the group home did not indicate documentation of client A being included in the interview/investigation. The 1/22/14 SIIR indicated the facility completed the investigation regarding client A's 1/9/14 incident of elopement on 1/22/14. The SIIR dated 1/22/14 indicated client A was not interviewed during the investigation. The 1/22/14 SIIR's interview notes with HM #1 indicated:</p>		<p>Plans. Responsible Party: Home Manager, Program Director, Behavior Specialist, Day Service staff, Area Director</p>				

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	<p>-"[Client A's] IDT had discussed his risk of elopement, but there is currently no plan in place to address this."</p> <p>-"... left the group home just before 5:00 PM on 1/9/14. Said she received a call approximately 10 minutes later informing her [client A] had vacated the home, but was stopped near the van and had returned to the group home. Said she was informed that the staff was going to hide [client A's] coat and shoes."</p> <p>The 1/22/14 SIIR's interview notes with staff #1 indicated:</p> <p>-"Said [staff #2] took [client A's] shoes and coat from him in an attempt to keep him from vacating the home again."</p> <p>The 1/22/14 SIIR's interview notes with staff #2 indicated:</p> <p>-"Said he used his own 'discretion' in taking [client A's] coat and shoes thinking he would not leave if he did not have these items."</p> <p>The 1/22/14 SIIR's conclusion indicated, "Evidence supports staff are not properly trained to work with [client A]. Evidence supports staff used what they thought was their best judgement in an attempt to keep [client A] from vacating." The 1/22/14</p>			

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	<p>SIIR did not indicate conclude with substantiated neglect regarding client A's 1/9/14 elopement.</p> <p>-Recommendations resulting from an Investigation (RRI) form dated 1/9/14 included the recommendation to convene the IDT to develop client A's BSP (Behavior Support Plan), RMAP (Risk Management Assessment Plan), ISP (Individual Support Plan), CST (Client Specific Training)...." The 1/22/14 recommendations did not address facility staff and/or HM #1 taking client A's coat and shoes to prevent him from elopement.</p> <p>2. BDDS report dated 2/19/14, 11:15 AM indicated, "[Client A] reported to his supervisor that he was not feeling well. [Client A] reported that he had an upset stomach and staff discussed to find that he was reporting that it was due to noise. Staff discussed and [client A] wanted to go outside. Staff walked outside with [client A] then went to call his residential staff to discuss. [Day service] staff called [RM #1 (Residential Manager)] and left a message immediately returning to where [client A] was. [Client A] was no longer there and staff began an immediate search of the area. [Client A] could not be found so staff began to search the neighborhood and called residential provider back.</p>				

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	<p>Residential staff discovered that [client A] was at the [community] library and went to pick him up at approximately 1:00 PM. Plan to resolve: Team will meet to discuss appropriate safety parameters." The 2/19/14 BDDS report indicated client A was out of supervision from 11:15 AM through 1:00 PM. The 2/19/14 BDDS report indicated day service staff left client A outside unattended.</p> <p>-SIIR dated 2/26/14 regarding client A's 2/19/14 elopement from day program did not indicate documentation of an interview with client A regarding the incident. The 2/26/14 SIIR indicated HM #1 and Day Program Manager (DPM) #1 were interviewed. Client A's 2/26/14 SIIR indicated day program staff had allowed client A to go outside while at the day program unattended. The 2/26/14 SIIR interview with DPM #1 indicated "... he forgot that [client A] was an elopement risk." The 2/26/14 SIIR conclusion indicated, "Evidence supports [client A] went to a place he was familiar with where he felt comfortable and safe. Evidence supports [day program] implemented an immediate search for [client A] when it was determined he was not in visual range." The 2/26/14 SIIR conclusion did not indicate documentation of review of the</p>						

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	<p>circumstances of client A's 2/19/14 elopement to determine if abuse, neglect or mistreatment had occurred.</p> <p>-Recommendations resulting from an Investigation form dated 2/20/14 included the following recommendations regarding client A's 2/29/14 elopement "Ensure day program has a copy and are trained on [client A's] BSP. Complete an ISP and RMAP and train staff to complete client specific training."</p> <p>The facility's staff training log was reviewed on 3/10/14 at 9:05 AM. Client A's 1/29/14 Inservice training report did not indicate documentation of facility staff being trained regarding client A's 1/29/14 ISP and/or RMAP.</p> <p>3. BDDS report dated 2/20/14 indicated, "BDDS generalist received a call from [APSI (Adult Protective Services Investigator) #1], with concerns about the elopements and safety at the [group home]. [APSI #1] indicated the BQIS (Bureau of Quality Improvement Services) incident reports do not match the police report she receives from the police. [APSI #1] indicated she received a call from the police that indicated there are more elopements from the house, in addition, they are frequently called out to the [group home]. [APSI #1] indicated</p>			
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	<p>[client A] eloped on 1/9/14 and was gone for 4 hours. Police found [client A] without a coat or shoes. Review of the BQIS incident report does not reflect this information. [APSI #1] indicated another client has a history of eloping as well. [APSI #1] is concerned about the number of staff in the group home. Incident Coding Category/Classification: Alleged neglect."</p> <p>-The review did not indicate documentation of an investigation regarding the 2/20/14 BDDS allegation of neglect.</p> <p>Client A's record was reviewed on 3/6/14 at 11:06 AM. Client A's BSP dated 1/20/14 indicated the following:</p> <p>-"Due to the frequent attempts to elope/vacate, [client A] is to remain in a 'line of sight' perimeter at all times during waking hours."</p> <p>-"The staff should pay special attention to [client A's] mood and behavior. If the staff member suspects [client A] is getting agitated and his behavior may escalate, attempt to redirect [client A] to an activity in an area... that does not have direct access to outside.... The one-on-one staff should also pay special attention to [client A] when he is near any</p>						

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	<p>door leading to the outside.... The staff should always be closest to the door when in a room with [client A]."</p> <p>-"Component 1: Vacating. Warning Signs/Proactive-Preventative: Staff should be aware of [client A's] whereabouts at all times. In inclement weather, keep protective clothing for staff and [client A] near the door so that it is easily available if [client A] exits the home. [Client A] also has an alarm attached to his door to alert staff when he has left his room."</p> <p>-"Responding to Elopement: Staff should implement the following steps regarding vacating:</p> <ol style="list-style-type: none"> 1. If staff suspects [client A] is getting agitated and his behavior may escalate, attempt to redirect [client A] to an activity in another area of the house that does not have direct access to outside the home. 2. If staff observes [client A] attempting to leave, prompt him to stop and remain within the program area. If [client A] does as requested, resume the ongoing activity with no further comment. 3. If staff observes [client A] attempting to leave and he ignores the prompt to 			

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	<p>stop, the staff should use agency approved physical intervention techniques to prevent [client A] from leaving home.</p> <p>4. If staff is unable to stop [client A] and he leaves anyway, the one-on-one staff member responsible for his program must exit with him and stay with him to protect him from danger. Due to [client A's] fast nature, the location of his home, and his history of property damage when he vacates, the one-on-one staff member should use agency approved physical intervention techniques to stop [client A]. Staff should attempt to keep [client A] away from the road, other homes, property, and/or vehicles.</p> <p>5a. If necessary, and if additional staff are available, a second staff member should exit the home and assist the one-on-one staff.</p> <p>5b. If [client A] and the one-on-one staff are in eyesight, the additional staff member should assist on foot.</p> <p>5c. If [client A] and the one-on-one staff are out of eyesight, the additional staff should use the van to find [client A] and his one-on-one staff to assist.</p> <p>5d. If at any time [client A] has vacated</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G418	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/11/2014
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5105 N GUION RD INDIANAPOLIS, IN 46254
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	<p>and two or more staff are available and in [client A's] reach they should use agency approved physical intervention techniques to stop [client A].</p> <p>6. When [client A] is contained, escort him to a safe location and keep him under observation until you are sure he will not vacate again. Limit conversation with [client A] for ten minutes.</p> <p>7. If you are unable to catch up with [client A] after ten minutes, contact the on-call supervisor for further instructions.</p> <p>8. If you do not see [client A] leave the area, contact the on-call supervisor as soon as you notice he is gone and initiate search procedures; (If at any point [client A] is no longer in eyesight, immediately contact 911 and the on-call supervisor."</p> <p>Client A's 2/24/14 IDT meeting form indicated the facility IDT had convened to discuss client A's 2/19/14 elopement from his day service provider. The 2/24/14 IDT's recommendations included "Forward over new BSP to [day program]."</p> <p>QAS (Quality Assurance Staff) #1 was interviewed on 3/5/14 at 2:45 PM. QAS #1 indicated the 2/20/14 allegation of neglect regarding client A was not</p>			
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	<p>investigated. QAS #1 stated, "I did go to the house and review the charts and talked to the staff that were there at the time. There is not a formal investigation. I didn't type my notes up for a formal investigation."</p> <p>AD (Area Director) #1 was interviewed on 3/6/14 at 12:01 PM. AD #1 indicated the facility had not provided the day program with a copy of client A's 1/20/14 BSP. AD #1 indicated the day program staff had not been trained regarding client A's 1/20/14 BSP. AD #1 indicated the day program staff should be trained on client A's BSP. AD #1 indicated client A's 1/20/14 BSP should be implemented at client A's day program. AD #1 indicated client A required 24 supervision for his health and safety. AD #1 indicated client A was verbal and could answer yes and no questions. AD #1 indicated client A should be included in investigation interviews regarding abuse, neglect and mistreatment.</p> <p>4. BDDS report dated 10/22/13 indicated, "[Client B] was walking around the house saying 'Call the police, I'm ready to go to jail', [HM #1] was there and called the police just so they could come talk to [client B] to try to calm him down. [Client B] eloped, but he wears a Project Lifesaver bracelet on his ankle and police</p>						

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	<p>were able to locate him. He was gone approximately an hour." The 10/22/13 BDDS report indicated, "Plan to resolve: [Client B] had some cuts and bruises and was taken to [hospital's] individual detention area for evaluation. At about 1:30 AM, [hospital] called and [HM #1] picked up [client B] and returned to the group home. [Client B] resumed his normal routine and went to day placement this morning. Vacating is in [client B's] BSP (Behavior Support Plan). Continue to follow BSP and monitor for health and safety." The 10/22/13 BDDS report did not indicate documentation of facility staff's attempts to redirect client B to an activity in another area of the house that does not have direct access to the outside of the home, prompt client B to remain within the program area, or attempt to utilize agency approved physical intervention techniques to respond to client B's elopement behavior. The 10/22/13 BDDS report did not indicate documentation of facility staff exiting the group home to protect client B from danger or of facility staff utilizing additional staff with the facility van to locate client B.</p> <p>The review did not indicate documentation of an investigation regarding client B's 10/22/13 elopement and evasion of staff supervision.</p>			

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	<p>5. BDDS report dated 1/21/14 indicated, "Staff (unspecified) noticed [client B] trying to elope out his bedroom window. [Client B] was able to get out of his bedroom window and staff was able to follow him and keep him in sight. Staff notified [HM #1 (Home Manager)] and followed elopement protocol and called the police for assistance. Staff was able to get [client B] to go back home and follow directives. Police came out to group home and talked with [client B] about safety." The 1/21/14 BDDS report indicated, "Plan to Resolve: Staff will continue to monitor [client B's] health and safety." The 1/21/14 BDDS report did not indicate documentation of facility staff's use or attempted use of agency approved physical intervention techniques. The 1/21/14 BDDS report did not indicate documentation of client B evading facility staff's supervision during the elopement incident or client B attempting to enter a home other than the group home.</p> <p>6. BDDS report dated 3/2/14 indicated, "On 3/2/14, [client B] eloped from his group home through a window. Staff noticed him missing and went looking for him quickly. Staff found [client B] hiding in the bushes nearby the group home. [Client B] refused to come back to the</p>			
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	<p>group home with staff. Staff called the police and they were able to get [client B] to go back to the group home." The 3/2/14 BDDS report indicated, "Plan to resolve: Staff will monitor [client B] for his health and safety. Staff will follow [client B's] BSP for elopement." The 3/2/14 BDDS report did not indicate documentation of facility staff's use or attempted use of agency approved physical intervention techniques. The 3/2/14 BDDS report did not indicate documentation of client B evading facility staff's supervision during the elopement incident or client B attempting to enter a home other than the group home.</p> <p>Client B's record was reviewed on 3/7/14 at 2:42 PM. Client B's BSP dated 3/10/13 indicated the following:</p> <p>-"Component 1: Vacating. Warning Signs/Proactive-Preventative: Staff should be aware of [client B's] whereabouts at all times. In inclement weather, keep protective clothing for staff and [client B] near the door so that it is easily available if [client B] exits the home. [Client B] also has an alarm attached to his door to alert staff when he has left his room."</p> <p>-"Responding to Elopement: Staff should</p>						

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	<p>implement the following steps regarding vacating:</p> <ol style="list-style-type: none"> 1. If staff suspects [client B] is getting agitated and his behavior may escalate, attempt to redirect [client B] to an activity in another area of the house that doesn't have direct access to outside the home. 2. If staff observes [client B] attempting to leave, prompt him to stop and remain within the program area. If [client B] does as requested, resume the ongoing activity with no further comment. 3. If staff observes [client B] attempting to leave and he ignores the prompt to stop, the staff should use agency approved physical intervention techniques to prevent [client B] from leaving home. 4. If staff is unable to stop [client B] and he leaves anyway, the one-on-one staff member responsible for his program must exit with him and stay with him to protect him from danger. Due to [client B's] fast nature, the location of his home, and his history of property damage when he vacates, the one-on-one staff member should use agency approved physical intervention techniques to stop [client B]. Staff should attempt to keep [client B] 			
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	<p>away from the road, other homes, property, and/or vehicles.</p> <p>5a. If necessary, and if additional staff are available, a second staff member should exit the home and assist the one-on-one staff.</p> <p>5b. If [client B] and the one-on-one staff are in eyesight, the additional staff member should assist on foot.</p> <p>5c. If [client B] and the one-on-one staff are out of eyesight, the additional staff should use the van to find [client B] and his one-on-one staff to assist.</p> <p>5d. If at any time [client B] has vacated and two or more staff are available and in [client B's] reach they should use agency approved physical intervention techniques to stop [client B].</p> <p>6. When [client B] is contained, escort him to a safe location and keep him under observation until you are sure he will not vacate again. Limit conversation with [client B] for ten minutes.</p> <p>7. If you are unable to catch up with [client B] after ten minutes, contact the on-call supervisor for further instructions.</p> <p>8. If you do not see [client B] leave the</p>				

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	<p>area, contact the on-call supervisor as soon as you notice he is gone and initiate search procedures; (If at any point [client B] is no longer in eyesight, immediately contact 911 and the on-call supervisor."</p> <p>Client B's ISP dated 6/3/13 indicated client B should have 24 hours supervision.</p> <p>AD #1 was interviewed on 3/6/14 at 12:01 PM. AD #1 indicated the staff should attempt to redirect client B to an activity in another area of the house that does not have direct access to the outside of the home, prompt client B to remain within the program area, or attempt to utilize agency approved physical intervention techniques to respond to client B's elopement behavior, staff should exit the group home/follow client B to protect him from danger and staff should utilize additional staff with the facility van to locate client B before calling 911 for assistance. AD #1 indicated staff did not implement client B's BSP during client B's 10/22/13, 1/21/14 and 3/2/14 incidents of elopement. AD #1 indicated facility staff had not been retrained regarding implementation of client B's BSP to prevent or respond to incidents of client B's elopement behaviors. AD #1 indicated failure to implement a care plan</p>			

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	<p>as written was program intervention neglect. AD #1 indicated client B's 10/22/13 incident of elopement should have been investigated. AD #1 indicated client B was assessed as being a risk to himself or others while in the community unsupervised. AD #1 indicated client B should have 24 hour supervision to ensure his health and safety. AD #1 indicated all allegations of abuse, neglect and mistreatment should be thoroughly investigated. AD #1 indicated the results of investigations should be reported to the administrator within 5 business days of the incident. AD #1 indicated the facility should develop and implement corrective action to prevent reoccurrence of abuse, neglect or mistreatment. AD #1 indicated the facility's abuse and neglect policy should be implemented.</p> <p>The facility's policy and procedures were reviewed on 3/7/14 at 2:02 PM. The facility's April 2011 policy and procedure entitled Quality Risk Management 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. (1.) Investigation findings will be submitted to the Area Director for review and development of further recommendations as needed within 5 days of the incident."</p>			
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	<p>The April 2011 Quality Risk Management policy indicated, "4. A service delivery site that compromises the health and safety of an individual while the individual is receiving services from the following causes:...(c.) Elopement of an individual that results in evasion of required supervision as described in the ISP for health and welfare; (d.) Missing person when an individual wanders away and no one knows where they are... (f.) Event with the potential for causing significant harm or injury and requiring medical or psychiatric treatments or services to or for an individual receiving services;...; (p.) Inadequate staff support for an individual, including inadequate supervision, with the potential (1) Significant harm or injury to an individual; or (2) death of individual."</p> <p>This federal tag relates to complaint #IN00144956.</p> <p>9-3-2(a)</p>						

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 4 of 15 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed (clients A and B), the facility failed to conduct an investigation regarding an allegation of neglect for client A, failed to conduct a thorough investigation regarding two separate incidents of elopement for client A and one incident of elopement for client B.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services Reports) and investigations were reviewed on 3/5/14 at 2:30 PM. The review indicated the following:</p> <p>1. BDDS report dated 1/10/14 indicated, "[Client A] wanted to go to the gas station to purchase some snacks. Staff asked [client A] to wait until schedule(d) activities were completed to go. [Client A] went to his room and staff continued with group home activity. Staff went to [client A's] room to get him for medication pass and discovered [client A] had eloped from group home. Staff</p>	W000154	<p>The Program Director and Quality Assurance Specialist will receive retraining on ensuring that investigations are completed for any incidents that may indicate potential abuse, neglect or mistreatment of clients has occurred.</p> <p>The Program Director and Quality Assurance Specialist will receive retraining on investigations including reporting to the administrator or designee the results within 5 work days and also ensuring that all parties related to the incident are interviewed so that a thorough investigation can be completed. The Area Director will track all incidents for which ones require an investigation. If an incident requires an investigation, the Area Director will track that investigations are being completed and being completed within the 5 business day guidelines. As it is getting close to the 5 day mark, if the Area Director has not received a required investigation, the Area Director will provide feedback to the Program Director and/or the Quality Assurance Specialist to inquire as to the status of the investigation.</p> <p>All future incident reports will be reviewed by the Area Director and</p>	04/10/2014
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	<p>noticed (sic) [HM #1 (Home Manager)] and [HM #1] instructed staff to notify the police. Police came to the group house (sic) 30 minutes after initial call to inform staff that [client A] was located and taken to [hospital] for further evaluation. Plan to resolve: [Client A] was evaluated by hospital staff and was released back to group home. [Client A] was placed on line of sight supervision protocol until IDT (Interdisciplinary Team) meeting is able to meet to discuss [client A's] health and safety. Staff was suspended pending investigation."</p> <p>-Police report dated 1/9/14 at 8:44 PM indicated, "On 1/9/14 at 1751 hours (5:51 PM), [officer #1], was dispatched to the 4800 block of [street] to investigate a report of a teenage BM (Black Male) wearing only a brown t-shirt, blue jeans with no shoes or coat walking south on [street]. The above run was initiated at 1748 hours (5:48 PM) and officers located the above individual in the 4400 block of [street] at 1759 hours (5:59 PM) walking south bound on [street]. After locating the above individual, later identified as [client A], I was able to observe that he was only wearing a t-shirt and jeans and had his shoulder hunched upwards with his hands out which appeared as if [client A] was very cold. I activated my overhead lights and [client</p>		<p>Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made. Responsible Party: Program Director, Regional Quality Assurance Specialist, Area Director.</p>				

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	A] turned to look and stopped. I approached [client A] and asked his name and where he lived. [Client A] provided me his name which I was later able to verify was accurate. [Client A] stated that he lived in [neighborhood] on [address] and stated that he did not know how he got to where he currently was. I was able to observe that [client A] was not wearing any shoes and that his socks were completely soaked as he had been walking in the slush on the side of the road. I placed [client A] in the back of my police vehicle to help him warm up and called for a medic to provide a checkout of [client A] due to the fact that the temperature was very cold combined with the lack of clothing that he was wearing. [Medic] arrived on scene and stated that it was possible that [client A] was hypothermic. I conducted a search of [client A] through case request and found that [client A] had been placed under immediate detention in the past and that he was autistic. I attempted to make contact with [client A's] mother from telephone numbers from past reports with no success. Due to the fact that officers were unable to confirm where [client A] was currently living, how he arrived at the location where he was found by officers along with the fact that [client A] was walking on a busy, snow covered street during rush hour traffic in very cold			
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	<p>temperatures with no coat or shoes, officers placed [client A] under immediate detention. [Client A] was transported by [ambulance] to [hospital].</p> <p>At 2044 hours (8:44 PM), on 1/9/14, [officer #1] and [officer #2], received a radio dispatched run to [group home] on a missing person. 911 caller stated to dispatchers that a BM, who is the above individual, was last seen five minutes ago from the time of the 911 call walking out the door. Officers cleared the run and control operations confirmed that [client A] was still currently at [hospital]. Upon my arrival on scene at [group home] I spoke with [staff #1] (sic) stated that [client A] had last been seen about five minutes prior to the 911 call and that she did not know where he was. [Staff #1] and the rest of the staff were not aware that [client A] had been transported to the hospital several hours prior to them finally realizing that he was missing. [Staff #1] stated that she was serving the snack and that she yelled for [client A] to come eat and was unable to locate him. [Staff #1] stated that earlier in the day at what she said was about 1700 hours (5:00 PM), [client A] had left the house and made it to the end of the driveway before staff were able to bring him back inside. [Staff #1] stated that once inside [staff #2] took [client A's] shoes and coat to</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G418	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/11/2014
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5105 N GUION RD INDIANAPOLIS, IN 46254
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	<p>prevent [client A] from exiting the house again. [Staff #1] would later state that other staff members may have realized [client A] was missing prior to snack time when they give the residents there (sic) medication usually between 2030 hours and 2045 hours. [Staff #1] stated that after they had brought [client A] back inside after the first time he left, she had set the door alarms which she stated alerts the staff that a door had been opened. I went to three separate doors in the house and opened each one. On each door, when it was opened, no alarm sounded. [Staff #1] was able to get the door alarm to work and when the alarm sounded it was so faint that it could only be heard from the living room. I then spoke with [staff #2] about the incident, [staff #2], stated to officers that he last saw [client A] at around 1900 hours and that he realized that [client A] was missing when he was giving the residents there (sic) medication at about 2000 hours (8:00 PM). [Staff #2] stated that he then left the house to go look for [client A]. I advised house staff that [client A] had been located by officers approximately a half a mile down the road walking in the road with no shoes or coat at about 1759 (5:59 PM). I also advised the staff that [client A] was currently at [hospital] under immediate detention and receiving medical attention</p>			
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5105 N GUION RD INDIANAPOLIS, IN 46254		
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	<p>for being in the cold for a period of time without proper attire. Over the past year officers have responded to this group home numerous times to assist in locating special needs residents who have left the house. Due to the fact that [client A], a special needs resident who at the time was under the direct supervision and care of the group home staff was able to exit the house into poor weather conditions for several hours prior to group home staff realizing he was gone (sic)."</p> <p>-Summary of Internal Investigation Report (SIIR) dated 1/22/14 regarding client A's 1/9/14 elopement from the group home did not indicate documentation of client A being included in the interview/investigation.</p> <p>The 1/22/14 SIIR's conclusion indicated, "Evidence supports staff are not properly trained to work with [client A]. Evidence supports staff used what they thought was their best judgement in an attempt to keep [client A] from vacating." The 1/22/14 SIIR's conclusion did not substantiate neglect regarding client A's 1/9/14 elopement.</p> <p>2. BDDS report dated 2/19/14, 11:15 AM indicated, "[Client A] reported to his supervisor that he was not feeling well. [Client A] reported that he had an upset</p>				

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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5105 N GUION RD INDIANAPOLIS, IN 46254			
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	<p>stomach and staff discussed to find that he was reporting that it was due to noise. Staff discussed and [client A] wanted to go outside. Staff walked outside with [client A] then went to call his residential staff to discuss. [Day service] staff called [RM #1 (Residential Manager)] and left a message immediately returning to where [client A] was. [Client A] was no longer there and staff began an immediate search of the area. [Client A] could not be found so staff began to search the neighborhood and called residential provider back. Residential staff discovered that [client A] was at the [community] library and went to pick him up at approximately 1:00 PM. Plan to resolve: Team will meet to discuss appropriate safety parameters." The 2/19/14 BDDS report indicated client A was out of supervision from 11:15 AM through 1:00 PM. The 2/19/14 BDDS report indicated day service staff left client A outside unattended.</p> <p>-SIIR dated 2/26/14 regarding client A's 2/19/14 elopement from day program did not indicate documentation of an interview with client A regarding the incident. Client A's 2/26/14 SIIR indicated day program staff had allowed client A to go outside while at the day program unattended. The 2/26/14 SIIR interview with DPM (Day Program</p>						

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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5105 N GUION RD INDIANAPOLIS, IN 46254
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	<p>Manager) #1 indicated "... he forgot that [client A] was an elopement risk." The 2/26/14 SIIR's conclusion indicated, "Evidence supports [client A] went to a place he was familiar with where he felt comfortable and safe. Evidence supports [day program] implemented an immediate search for [client A] when it was determined he was not in visual range." The 2/26/14 SIIR's conclusion did not substantiate neglect regarding client A's 1/9/14 elopement.</p> <p>-Recommendations resulting from an Investigation form dated 2/20/14 included the following recommendations regarding client A's 2/29/14 elopement "Ensure day program has a copy and are trained on [client A's] BSP. Complete an ISP and RMAP and train staff to complete client specific training."</p> <p>3. BDDS report dated 2/20/14 indicated, "BDDS generalist received a call from [APSI (Adult Protective Services Investigator) #1], with concerns about the elopements and safety at the [group home]. [APSI #1] indicated the BQIS (Bureau of Quality Improvement Services) incident reports do not match the police report she receives from the police. [APSI #1] indicated she received a call from the police that indicated there are more elopements from the house, in</p>			
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	<p>addition, they are frequently called out to the [group home]. [APSI #1] indicated [client A] eloped on 1/9/14 and was gone for 4 hours. Police found [client A] without a coat or shoes. Review of the BQIS incident report does not reflect this information. [APSI #1] indicated another client has a history of eloping as well. [APSI #1] is concerned about the number of staff in the group home. Incident Coding Category/Classification: Alleged neglect."</p> <p>-The review did not indicate documentation of an investigation regarding the 2/20/14 BDDS allegation of neglect.</p> <p>QAS (Quality Assurance Staff) #1 was interviewed on 3/5/14 at 2:45 PM. QAS #1 indicated the 2/20/14 allegation of neglect regarding client A was not investigated. QAS #1 stated, "I did go to the house and review the charts and talked to the staff that were there at the time. There is not a formal investigation. I didn't type my notes up for a formal investigation."</p> <p>AD (Area Director) #1 was interviewed on 3/6/14 at 12:01 PM. AD #1 indicated client A was verbal and could answer yes and no questions. AD #1 indicated client A should be included in investigation</p>			
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	<p>interviews regarding abuse, neglect and mistreatment. AD #1 indicated client A's 1/9/14 and 2/19/14 incidents of elopement were not thoroughly investigated to determine if abuse, neglect or mistreatment had occurred regarding prevention of client A's elopement and implementation of client A's BSP.</p> <p>4. BDDS report dated 10/22/13 indicated, "[Client B] was walking around the house saying 'Call the police, I'm ready to go to jail', [HM #1] was there and called the police just so they could come talk to [client B] to try to calm him down. [Client B] eloped, but he wears a Project Lifesaver bracelet on his ankle and police were able to locate him. He was gone approximately an hour." The 10/22/13 BDDS report indicated, "Plan to resolve: [Client B] had some cuts and bruises and was taken to [hospital's] individual detention area for evaluation. At about 1:30 AM, [hospital] called and [HM #1] picked up [client B] and returned to the group home. [Client B] resumed his normal routine and went to day placement this morning. Vacating is in [client B's] BSP (Behavior Support Plan). Continue to follow BSP and monitor for health and safety." The 10/22/13 BDDS report did not indicate documentation of facility staff's attempts to redirect client B</p>			
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5105 N GUION RD INDIANAPOLIS, IN 46254		
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	<p>to an activity in another area of the house that does not have direct access to the outside of the home, prompt client B to remain within the program area, or attempt to utilize agency approved physical intervention techniques to respond to client B's elopement behavior. The 10/22/13 BDDS report did not indicate documentation of facility staff exiting the group home to protect client B from danger or of facility staff utilizing additional staff with the facility van to locate client B.</p> <p>The review did not indicate documentation of an investigation regarding client B's 10/22/13 elopement and evasion of staff supervision.</p> <p>AD #1 was interviewed on 3/6/14 at 12:01 PM. AD #1 indicated client B's 10/22/13 elopement should have been investigated. AD #1 indicated client B was assessed as being a risk to himself or others while in the community unsupervised. AD #1 indicated client B should have 24 hour supervision to ensure his health and safety. AD #1 indicated all allegations of abuse, neglect and mistreatment should be thoroughly investigated.</p> <p>This federal tag relates to complaint #IN00144956.</p>				

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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5105 N GUION RD INDIANAPOLIS, IN 46254
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5105 N GUION RD INDIANAPOLIS, IN 46254
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W000156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 1 of 15 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed (client A), the facility failed to report the results of an allegation of neglect regarding client A's elopement to the facility administrator within 5 business days.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services Reports) and investigations were reviewed on 3/5/14 at 2:30 PM. The review indicated the following:</p> <p>BDDS report dated 1/10/14 indicated, "[Client A] wanted to go to the gas station to purchase some snacks. Staff asked [client A] to wait until schedule(d) activities were completed to go. [Client A] went to his room and staff continued with group home activity. Staff went to [client A's] room to get him for medication pass and discovered [client A] had eloped from group home. Staff noticed (sic) [HM #1 (Home Manager)]</p>	W000156	<p>The Program Director and Quality Assurance Specialist will receive retraining on investigations including reporting to the administrator or designee the results within 5 work days and also ensuring that all parties related to the incident are interviewed so that a thorough investigation can be completed.</p> <p>All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made.</p> <p>Responsible Party: Home Manager, Program Director, Regional Quality Assurance Specialist, Area Director.</p>	04/10/2014
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5105 N GUION RD INDIANAPOLIS, IN 46254		
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	<p>and [HM #1] instructed staff to notify the police. Police came to the group house (sic) 30 minutes after initial call to inform staff that [client A] was located and taken to [hospital] for further evaluation. Plan to resolve: [Client A] was evaluated by hospital staff and was released back to group home. [Client A] was placed on line of sight supervision protocol until IDT (Interdisciplinary Team) meeting is able to meet to discuss [client A's] health and safety. Staff was suspended pending investigation."</p> <p>-Summary of Internal Investigation Report (SIIR) dated 1/22/14 regarding client A's 1/9/14 elopement from the group home did not indicate the facility had completed the investigation within 5 business days of the incident.</p> <p>AD (Area Director) #1 was interviewed on 3/6/14 at 12:01 PM. AD #1 indicated the results of investigations should be reported to the administrator within 5 business days of the incident.</p> <p>This federal tag relates to complaint #IN00144956.</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G418	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5105 N GUION RD INDIANAPOLIS, IN 46254		
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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 5 of 15 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to develop and implement corrective actions to prevent neglect of clients A and B regarding elopement behaviors.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services Reports) and investigations were reviewed on 3/5/14 at 2:30 PM. The review indicated the following:</p> <p>1. BDDS report dated 1/10/14 indicated, "[Client A] wanted to go to the gas station to purchase some snacks. Staff asked [client A] to wait until schedule(d) activities were completed to go. [Client A] went to his room and staff continued with group home activity. Staff went to [client A's] room to get him for medication pass and discovered [client A] had eloped from group home. Staff noticed (sic) [HM #1 (Home Manager)] and [HM #1] instructed staff to notify the police. Police came to the group house (sic) 30 minutes after initial call to inform</p>	W000157	<p>Client A and Client B Behavior Support Plans have been updated to include addressing elopement behaviors, line of sight supervision, staff interventions for preventing elopement from the home and procedures for what to do if Client A or B elopes from the home.</p> <p>All Direct Care staff will receive retraining to include a review of Client A and B's ISP, RMAP and also updated Behavior Support Plans which include addressing elopement behaviors, line of sight supervision, staff interventions for preventing elopement from the home and procedures for what to do if Client A or B elopes from the home.</p> <p>Program Director will receive retraining to include ensuring that all Direct Care staff are trained on all consumers initial and updated Behavior Support Plans once complete so they are aware of which steps to use to monitor and prevent targeted consumer behaviors and which interventions to use if targeted behaviors occur. Ongoing the Program Director will ensure that all staff are trained on any initial and updated Behavior Support Plans once complete so they are aware of which steps to use to monitor and prevent targeted consumer behaviors and which interventions to use if</p>	04/10/2014	

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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5105 N GUION RD INDIANAPOLIS, IN 46254			
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	<p>staff that [client A] was located and taken to [hospital] for further evaluation. Plan to resolve: [Client A] was evaluated by hospital staff and was released back to group home. [Client A] was placed on line of sight supervision protocol until IDT (Interdisciplinary Team) meeting is able to meet to discuss [client A's] health and safety. Staff was suspended pending investigation."</p> <p>-Police report dated 1/9/14 at 8:44 PM indicated, "On 1/9/14 at 1751 hours (5:51 PM), [officer #1], was dispatched to the 4800 block of [street] to investigate a report of a teenage BM (Black Male) wearing only a brown t-shirt, blue jeans with no shoes or coat walking south on [street]. The above run was initiated at 1748 hours (5:48 PM) and officers located the above individual in the 4400 block of [street] at 1759 hours (5:59 PM) walking south bound on [street]. After locating the above individual, later identified as [client A], I was able to observe that he was only wearing a t-shirt and jeans and had his shoulder hunched upwards with his hands out which appeared as if [client A] was very cold. I activated my overhead lights and [client A] turned to look and stopped. I approached [client A] and asked his name and where he lived. [Client A] provided me his name which I was later able to</p>		<p>targeted behaviors occur. The Program Director will provide the Area Director will copies of the staff training once complete to ensure all staff are trained on BSP updates.</p> <p>Client A Day service provider has received a copy of Client A Behavior Support Plan. Client A Day Service Provider has received retraining on Client A Behavior Support Plan especially including the procedures for keeping Client A in line of sight supervision and ensuring that staff are monitoring Client A moods and behaviors to monitor for signs that he might elope. Program Director and Home Manager will receive retraining to include ensuring that all Day Service Providers receive retraining on any new or updated Behavior Support Plans for all clients.</p> <p>Ongoing, the Home Manager and/or Program Director will ensure that all Day Service Providers receive copies of all consumers Behavior Support Plans and receive retraining on any new plans or updates to current plans to ensure all recommendations are being implemented. Ongoing the Home Manager and/or Program Director will complete Day Service observations for each client a minimum of every 2 months to ensure that Day Service Providers are implementing Behavior Support Plans as</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G418	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 5105 N GUION RD INDIANAPOLIS, IN 46254		
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	verify was accurate. [Client A] stated that he lived in [neighborhood] on [address] and stated that he did not know how he got to where he currently was. I was able to observe that [client A] was not wearing any shoes and that his socks were completely soaked as he had been walking in the slush on the side of the road. I placed [client A] in the back of my police vehicle to help him warm up and called for a medic to provide a checkout of [client A] due to the fact that the temperature was very cold combined with the lack of clothing that he was wearing. [Medic] arrived on scene and stated that it was possible that [client A] was hypothermic. I conducted a search of [client A] through case request and found that [client A] had been placed under immediate detention in the past and that he was autistic. I attempted to make contact with [client A's] mother from telephone numbers from past reports with no success. Due to the fact that officers were unable to confirm where [client A] was currently living, how he arrived at the location where he was found by officers along with the fact that [client A] was walking on a busy, snow covered street during rush hour traffic in very cold temperatures with no coat or shoes, officers placed [client A] under immediate detention. [Client A] was transported by [ambulance] to [hospital].		written. The Program Director will receive retraining to include ensuring that when targeted behavior such as elopement occurs an investigation is completed to assess if staff followed consumers Behavior Support Plan interventions as directed. Based on the results of the investigation the Program Director will develop recommendation as needed regarding prevention of future targeted behaviors. The Program Director will receive retraining on the need to ensure Interdisciplinary Team meetings are held as needed for consumers once incidents of targeted behaviors, such as elopements, occur to determine if staff followed consumers Behavior Support Plans as directed and determine if other protective measures need to be put into place or if any changes need to be made to consumers Behavior Support Plans. Ongoing, the Program Director will ensure that Interdisciplinary Team meetings are held as needed for consumers once incidents of targeted behaviors, such as elopements, occur to determine if staff followed consumers Behavior Support Plans as directed and determine if other protective measures need to be put into place or if any		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G418		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/11/2014	
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	At 2044 hours (8:44 PM), on 1/9/14, [officer #1] and [officer #2], received a radio dispatched run to [group home] on a missing person. 911 caller stated to dispatchers that a BM, who is the above individual, was last seen five minutes ago from the time of the 911 call walking out the door. Officers cleared the run and control operations confirmed that [client A] was still currently at [hospital]. Upon my arrival on scene at [group home] I spoke with [staff #1] (sic) stated that [client A] had last been seen about five minutes prior to the 911 call and that she did not know where he was. [Staff #1] and the rest of the staff were not aware that [client A] had been transported to the hospital several hours prior to them finally realizing that he was missing. [Staff #1] stated that she was serving the snack and that she yelled for [client A] to come eat and was unable to locate him. [Staff #1] stated that earlier in the day at what she said was about 1700 hours (5:00 PM), [client A] had left the house and made it to the end of the driveway before staff were able to bring him back inside. [Staff #1] stated that once inside [staff #2] took [client A's] shoes and coat to prevent [client A] from exiting the house again. [Staff #1] would later state that other staff members may have realized [client A] was missing prior to snack time		changes need to be made to consumers Behavior Support Plans. Responsible Party: Home Manager, Program Director, Behavior Specialist, Day Service staff, Area Director				

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	<p>when they give the residents there (sic) medication usually between 2030 hours and 2045 hours. [Staff #1] stated that after they had brought [client A] back inside after the first time he left, she had set the door alarms which she stated alerts the staff that a door had been opened. I went to three separate doors in the house and opened each one. On each door, when it was opened, no alarm sounded. [Staff #1] was able to get the door alarm to work and when the alarm sounded it was so faint that it could only be heard from the living room. I then spoke with [staff #2] about the incident, [staff #2], stated to officers that he last saw [client A] at around 1900 hours and that he realized that [client A] was missing when he was giving the residents there (sic) mediation at about 2000 hours (8:00 PM). [Staff #2] stated that he then left the house to go look for [client A]. I advised house staff that [client A] had been located by officers approximately a half a mile down the road walking in the road with no shoes or coat at about 1759 (5:59 PM). I also advised the staff that [client A] was currently at [hospital] under immediate detention and receiving medical attention for being in the cold for a period of time without proper attire. Over the past year officers have responded to this group home numerous times to assist in locating special needs</p>			
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	<p>residents who have left the house. Due to the fact that [client A], a special needs resident who at the time was under the direct supervision and care of the group home staff was able to exit the house into poor weather conditions for several hours prior to group home staff realizing he was gone (sic)."</p> <p>-Summary of Internal Investigation Report (SIIR) dated 1/22/14 regarding client A's 1/9/14 elopement indicated, "Evidence supports staff are not properly trained to work with [client A]. Evidence supports staff used what they thought was their best judgement in an attempt to keep [client A] from vacating."</p> <p>-Recommendations resulting from an Investigation (RRI) form dated 1/9/14 included the recommendation to convene the IDT to develop client A's BSP (Behavior Support Plan), RMAP (Risk Management Assessment Plan), ISP (Individual Support Plan), CST (Client Specific Training)...." The 1/22/14 recommendations did not address facility staff and/or HM #1 taking client A's coat and shoes to prevent him from elopement.</p> <p>2. BDDS report dated 2/19/14, 11:15 AM indicated, "[Client A] reported to his supervisor that he was not feeling well.</p>				

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	<p>[Client A] reported that he had an upset stomach and staff discussed to find that he was reporting that it was due to noise. Staff discussed and [client A] wanted to go outside. Staff walked outside with [client A] then went to call his residential staff to discuss. [Day service] staff called [RM #1 (Residential Manager)] and left a message immediately returning to where [client A] was. [Client A] was no longer there and staff began an immediate search of the area. [Client A] could not be found so staff began to search the neighborhood and called residential provider back. Residential staff discovered that [client A] was at the [community] library and went to pick him up at approximately 1:00 PM. Plan to resolve: Team will meet to discuss appropriate safety parameters." The 2/19/14 BDDS report indicated client A was out of supervision from 11:15 AM through 1:00 PM. The 2/19/14 BDDS report indicated day service staff left client A outside unattended.</p> <p>-SIIR dated 2/26/14 indicated, "Evidence supports [client A] went to a place he was familiar with where he felt comfortable and safe. Evidence supports [day program] implemented an immediate search for [client A] when it was determined he was not in visual range."</p>			
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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 5105 N GUION RD INDIANAPOLIS, IN 46254			
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	<p>-Recommendations resulting from an Investigation form dated 2/20/14 included the following recommendations regarding client A's 2/29/14 elopement "Ensure day program has a copy and are trained on [client A's] BSP. Complete an ISP and RMAP and train staff to complete client specific training."</p> <p>The facility's staff training log was reviewed on 3/10/14 at 9:05 AM. Client A's 1/29/14 Inservice training report did not indicate documentation of facility staff being trained regarding client A's 1/29/14 ISP and/or RMAP.</p> <p>Client A's 2/24/14 IDT meeting form indicated the facility IDT had convened to discuss client A's 2/19/14 elopement from his day service provider. The 2/24/14 IDT's recommendations included "Forward over new BSP to [day program]."</p> <p>AD (Area Director) #1 was interviewed on 3/6/14 at 12:01 PM. AD #1 indicated the facility had not provided the day program with a copy of client A's 1/20/14 BSP. AD #1 indicated the day program staff had not been trained regarding client A's 1/20/14 BSP. AD #1 indicated the day program staff should be trained on client A's BSP.</p>						

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	<p>3. BDDS report dated 10/22/13 indicated, "[Client B] was walking around the house saying 'Call the police, I'm ready to go to jail', [HM #1] was there and called the police just so they could come talk to [client B] to try to calm him down. [Client B] eloped, but he wears a Project Lifesaver bracelet on his ankle and police were able to locate him. He was gone approximately an hour." The 10/22/13 BDDS report indicated, "Plan to resolve: [Client B] had some cuts and bruises and was taken to [hospital's] individual detention area for evaluation. At about 1:30 AM, [hospital] called and [HM #1] picked up [client B] and returned to the group home. [Client B] resumed his normal routine and went to day placement this morning. Vacating is in [client B's] BSP (Behavior Support Plan). Continue to follow BSP and monitor for health and safety." The 10/22/13 BDDS report did not indicate documentation of facility staff's attempts to redirect client B to an activity in another area of the house that does not have direct access to the outside of the home, prompt client B to remain within the program area, or attempt to utilize agency approved physical intervention techniques to respond to client B's elopement behavior. The 10/22/13 BDDS report did not indicate documentation of facility staff exiting the group home to protect client B</p>			

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	<p>from danger or of facility staff utilizing additional staff with the facility van to locate client B. The review did not indicate documentation of the development of recommendations to ensure facility staff implemented client B's BSP to prevent client B from elopement.</p> <p>4. BDDS report dated 1/21/14 indicated, "Staff (unspecified) noticed [client B] trying to elope out his bedroom window. [Client B] was able to get out of his bedroom window and staff was able to follow him and keep him insight. Staff notified [HM #1 (Home Manager)] and followed elopement protocol and called the police for assistance. Staff was able to get [client B] to go back home and follow directives. Police came out to group home and talked with [client B] about safety." The 1/21/14 BDDS report indicated, "Plan to Resolve: Staff will continue to monitor [client B's] health and safety." The 1/21/14 BDDS report did not indicate documentation of facility staff's use or attempted use of agency approved physical intervention techniques. The 1/21/14 BDDS report did not indicate documentation of client B evading facility staff's supervision during the elopement incident or client B attempting to enter a home other than the group home. The review did not indicate</p>			

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	<p>documentation of the development of recommendations to ensure facility staff implemented client B's BSP to prevent client B from elopement.</p> <p>5. BDDS report dated 3/2/14 indicated, "On 3/2/14, [client B] eloped from his group home through a window. Staff noticed him missing and went looking for him quickly. Staff found [client B] hiding in the bushes nearby the group home. [Client B] refused to come back to the group home with staff. Staff called the police and they were able to get [client B] to go back to the group home." The 3/2/14 BDDS report indicated, "Plan to resolve: Staff will monitor [client B] for his health and safety. Staff will follow [client B's] BSP for elopement." The 3/2/14 BDDS report did not indicate documentation of facility staff's use or attempted use of agency approved physical intervention techniques. The 3/2/14 BDDS report did not indicate documentation of client B evading facility staff's supervision during the elopement incident or client B attempting to enter a home other than the group home. The review did not indicate documentation of the development of recommendations to ensure facility staff implemented client B's BSP to prevent client B from elopement.</p>						

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	<p>Client B's record was reviewed on 3/7/14 at 2:42 PM. Client B's BSP dated 3/10/13 indicated the following:</p> <p>-"Component 1: Vacating. Warning Signs/Proactive-Preventative: Staff should be aware of [client B's] whereabouts at all times. In inclement weather, keep protective clothing for staff and [client B] near the door so that it is easily available if [client B] exits the home. [Client B] also has an alarm attached to his door to alert staff when he has left his room."</p> <p>-"Responding to Elopement: Staff should implement the following steps regarding vacating:</p> <ol style="list-style-type: none"> 1. If staff suspects [client B] is getting agitated and his behavior may escalate, attempt to redirect [client B] to an activity in another area of the house that doesn't have direct access to outside the home. 2. If staff observes [client B] attempting to leave, prompt him to stop and remain within the program area. If [client B] does as requested, resume the ongoing activity with no further comment. 3. If staff observes [client B] attempting to leave and he ignores the prompt to 			

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	<p>stop, the staff should use agency approved physical intervention techniques to prevent [client B] from leaving home.</p> <p>4. If staff is unable to stop [client B] and he leaves anyway, the one-on-one staff member responsible for his program must exit with him and stay with him to protect him from danger. Due to [client B's] fast nature, the location of his home, and his history of property damage when he vacates, the one-on-one staff member should sue agency approved physical intervention techniques to stop [client B]. Staff should attempt to keep [client B] away from the road, other homes, property, and/or vehicles.</p> <p>5a. If necessary, and if additional staff are available, a second staff member should exit the home and assist the one-on-one staff.</p> <p>5b. If [client B] and the one-on-one staff are in eyesight, the additional staff member should assist on foot.</p> <p>5c. If [client B] and the one-on-one staff are out of eyesight, the additional staff should use the van to find [client B] and his one-on-one staff to assist.</p> <p>5d. If at any time [client B] has vacated</p>			
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	<p>and two or more staff are available and in [client B's] reach they should use agency approved physical intervention techniques to stop [client B].</p> <p>6. When [client B] is contained, escort him to a safe location and keep him under observation until you are sure he will not vacate again. Limit conversation with [client B] for ten minutes.</p> <p>7. If you are unable to catch up with [client B] after ten minutes, contact the on-call supervisor for further instructions.</p> <p>8. If you do not see [client B] leave the area, contact the on-call supervisor as soon as you notice he is gone and initiate search procedures; (If at any point [client B] is no longer in eyesight, immediately contact 911 and the on-call supervisor."</p> <p>AD #1 was interviewed on 3/6/14 at 12:01 PM. AD #1 indicated the indicated staff should attempt to redirect client B to an activity in another area of the house that does not have direct access to the outside of the home, prompt client B to remain within the program area, or attempt to utilize agency approved physical intervention techniques to respond to client B's elopement behavior, staff should exit the group home/follow client B to protect him from danger and</p>				

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	<p>staff should utilize additional staff with the facility van to locate client B before calling 911 for assistance. AD #1 indicated staff did not implement client B's BSP during client B's 10/22/13, 1/21/14 and 3/2/14 incidents of elopement. AD #1 indicated facility staff had not been retrained regarding implementation of client B's BSP to prevent or respond to incidents of client B's elopement behaviors. AD #1 indicated the facility should develop and implement corrective action to prevent reoccurrence of abuse, neglect or mistreatment.</p> <p>This federal tag relates to complaint #IN00144956.</p> <p>9-3-2(a)</p>			

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W000159	<p>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 on record review and interview for 2 of 4 sampled clients (A and B), the QIDP (Qualified Intellectual Disabilities Professional) failed to monitor, coordinate and integrate each client's active treatment program by failing to ensure facility staff were trained to work with clients A and B to address their ongoing elopement incidents from the group home.</p> <p>Findings include:</p> <p>The QIDP failed to monitor, coordinate and integrate each client's active treatment program by failing to ensure facility staff were trained to work with clients A and B to address their ongoing elopement incidents from the group home. Please see W189.</p> <p>This federal tag relates to complaint #IN00144956.</p> <p>9-3-3(a)</p>	W000159	<p>Client A and Client B Behavior Support Plans have been updated to include addressing elopement behaviors, line of sight supervision, staff interventions for preventing elopement from the home and procedures for what to do if Client A or B elopes from the home.</p> <p>All Direct Care staff will receive retraining to include a review of Client A and B's ISP, RMAP and also updated Behavior Support Plans which include addressing elopement behaviors, line of sight supervision, staff interventions for preventing elopement from the home and procedures for what to do if Client A or B elopes from the home.</p> <p>Program Director will receive retraining to include ensuring that all Direct Care staff are trained on all consumers initial and updated Behavior Support Plans once complete so they are aware of which steps to use to monitor and prevent targeted consumer behaviors and which interventions to use if targeted behaviors occur. Ongoing the Program Director will ensure that all staff are trained on any initial and updated Behavior Support Plans once complete so they are aware of which steps to use to monitor and prevent</p>	04/10/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G418	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/11/2014
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			<p>targeted consumer behaviors and which interventions to use if targeted behaviors occur. The Program Director will provide the Area Director will copies of the staff training once complete to ensure all staff are trained on BSP updates.</p> <p>Client A Day service provider has received a copy of Client A Behavior Support Plan. Client A Day Service Provider has received retraining on Client A Behavior Support Plan especially including the procedures for keeping Client A in line of sight supervision and ensuring that staff are monitoring Client A moods and behaviors to monitor for signs that he might elope. Program Director and Home Manager will receive retraining to include ensuring that all Day Service Providers receive retraining on any new or updated Behavior Support Plans for all clients.</p> <p>Ongoing, the Home Manager and/or Program Director will ensure that all Day Service Providers receive copies of all consumers Behavior Support Plans and receive retraining on any new plans or updates to current plans to ensure all recommendations are being implemented. Ongoing the Home Manager and/or Program Director will complete Day Service observations for each client a minimum of every 2 months to ensure that Day Service</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G418	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/11/2014
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			<p>Providers are implementing Behavior Support Plans as written.</p> <p>The Program Director will receive retraining to include ensuring that when targeted behavior such as elopement occurs an investigation is completed to assess if staff followed consumers Behavior Support Plan interventions as directed. Based on the results of the investigation the Program Director will develop recommendation as needed regarding prevention of future targeted behaviors.</p> <p>Responsible Party: Home Manager, Program Director, Behavior Specialist, Day Service staff, Area Director</p>	

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W000189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview for 2 of 4 sampled clients (A and B), the facility failed to ensure staff were sufficiently trained to work with clients A and B to address their ongoing incidents of elopement from the group home.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services Reports) and investigations were reviewed on 3/5/14 at 2:30 PM. The review indicated the following:</p> <p>1. BDDS report dated 1/10/14 indicated, "[Client A] wanted to go to the gas station to purchase some snacks. Staff asked [client A] to wait until schedule(d) activities were completed to go. [Client A] went to his room and staff continued with group home activity. Staff went to [client A's] room to get him for medication pass and discovered [client A] had eloped from group home. Staff noticed (sic) [HM #1 (Home Manager)] and [HM #1] instructed staff to notify the police. Police came to the group house</p>	W000189	Client A and Client B Behavior Support Plans have been updated to include addressing elopement behaviors, line of sight supervision, staff interventions for preventing elopement from the home and procedures for what to do if Client A or B elopes from the home. All Direct Care staff will receive retraining to include a review of Client A and B's ISP, RMAP and also updated Behavior Support Plans which include addressing elopement behaviors, line of sight supervision, staff interventions for preventing elopement from the home and procedures for what to do if Client A or B elopes from the home. Program Director will receive retraining to include ensuring that all Direct Care staff are trained on all consumers initial and updated Behavior Support Plans once complete so they are aware of which steps to use to monitor and prevent targeted consumer behaviors and which interventions to use if targeted behaviors occur. Ongoing the Program Director will ensure that all staff are trained on any initial and updated Behavior Support Plans once complete so they are aware of which steps to use to monitor and prevent	04/10/2014			

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	<p>(sic) 30 minutes after initial call to inform staff that [client A] was located and taken to [hospital] for further evaluation. Plan to resolve: [Client A] was evaluated by hospital staff and was released back to group home. [Client A] was placed on line of sight supervision protocol until IDT (Interdisciplinary Team) meeting is able to meet to discuss [client A's] health and safety. Staff was suspended pending investigation."</p> <p>-Police report dated 1/9/14 at 8:44 PM indicated, "On 1/9/14 at 1751 hours (5:51 PM), [officer #1], was dispatched to the 4800 block of [street] to investigate a report of a teenage BM (Black Male) wearing only a brown t-shirt, blue jeans with no shoes or coat walking south on [street]. The above run was initiated at 1748 hours (5:48 PM) and officers located the above individual in the 4400 block of [street] at 1759 hours (5:59 PM) walking south bound on [street]. After locating the above individual, later identified as [client A], I was able to observe that he was only wearing a t-shirt and jeans and had his shoulder hunched upwards with his hands out which appeared as if [client A] was very cold. I activated my overhead lights and [client A] turned to look and stopped. I approached [client A] and asked his name and where he lived. [Client A] provided</p>		targeted consumer behaviors and which interventions to use if targeted behaviors occur. The Program Director will provide the Area Director will copies of the staff training once complete to ensure all staff are trained on BSP updates. Client A Day service provider has received a copy of Client A Behavior Support Plan. Client A Day Service Provider has received retraining on Client A Behavior Support Plan especially including the procedures for keeping Client A in line of sight supervision and ensuring that staff are monitoring Client A moods and behaviors to monitor for signs that he might elope. Program Director and Home Manager will receive retraining to include ensuring that all Day Service Providers receive retraining on any new or updated Behavior Support Plans for all clients. Ongoing, the Home Manager and/or Program Director will ensure that all Day Service Providers receive copies of all consumers Behavior Support Plans and receive retraining on any new plans or updates to current plans to ensure all recommendations are being implemented. Ongoing the Home Manager and/or Program Director will complete Day Service observations for each client a minimum of every 2 months to ensure that Day Service Providers are implementing Behavior Support Plans as				

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	me his name which I was later able to verify was accurate. [Client A] stated that he lived in [neighborhood] on [address] and stated that he did not know how he got to where he currently was. I was able to observe that [client A] was not wearing any shoes and that his socks were completely soaked as he had been walking in the slush on the side of the road. I placed [client A] in the back of my police vehicle to help him warm up and called for a medic to provide a checkout of [client A] due to the fact that the temperature was very cold combined with the lack of clothing that he was wearing. [Medic] arrived on scene and stated that it was possible that [client A] was hypothermic. I conducted a search of [client A] through case request and found that [client A] had been placed under immediate detention in the past and that he was autistic. I attempted to make contact with [client A's] mother from telephone numbers from past reports with no success. Due to the fact that officers were unable to confirm where [client A] was currently living, how he arrived at the location where he was found by officers along with the fact that [client A] was walking on a busy, snow covered street during rush hour traffic in very cold temperatures with no coat or shoes, officers placed [client A] under immediate detention. [Client A] was		written. The Program Director will receive retraining to include ensuring that when targeted behavior such as elopement occurs an investigation is completed to assess if staff followed consumers Behavior Support Plan interventions as directed. Based on the results of the investigation the Program Director will develop recommendation as needed regarding prevention of future targeted behaviors. Responsible Party: Home Manager, Program Director, Behavior Specialist, Day Service staff, Area Director	

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	<p>transported by [ambulance] to [hospital].</p> <p>At 2044 hours (8:44 PM), on 1/9/14, [officer #1] and [officer #2], received a radio dispatched run to [group home] on a missing person. 911 caller stated to dispatchers that a BM, who is the above individual, was last seen five minutes ago from the time of the 911 call walking out the door. Officers cleared the run and control operations confirmed that [client A] was still currently at [hospital]. Upon my arrival on scene at [group home] I spoke with [staff #1] (sic) stated that [client A] had last been seen about five minutes prior to the 911 call and that she did not know where he was. [Staff #1] and the rest of the staff were not aware that [client A] had been transported to the hospital several hours prior to them finally realizing that he was missing. [Staff #1] stated that she was serving the snack and that she yelled for [client A] to come eat and was unable to locate him. [Staff #1] stated that earlier in the day at what she said was about 1700 hours (5:00 PM), [client A] had left the house and made it to the end of the driveway before staff were able to bring him back inside. [Staff #1] stated that once inside [staff #2] took [client A's] shoes and coat to prevent [client A] from exiting the house again. [Staff #1] would later state that other staff members may have realized</p>			

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	<p>[client A] was missing prior to snack time when they give the residents there (sic) medication usually between 2030 hours and 2045 hours. [Staff #1] stated that after they had brought [client A] back inside after the first time he left, she had set the door alarms which she stated alerts the staff that a door had been opened. I went to three separate doors in the house and opened each one. On each door, when it was opened, no alarm sounded. [Staff #1] was able to get the door alarm to work and when the alarm sounded it was so faint that it could only be heard from the living room. I then spoke with [staff #2] about the incident, [staff #2], stated to officers that he last saw [client A] at around 1900 hours and that he realized that [client A] was missing when he was giving the residents there (sic) medication at about 2000 hours (8:00 PM). [Staff #2] stated that he then left the house to go look for [client A]. I advised house staff that [client A] had been located by officers approximately a half a mile down the road walking in the road with no shoes or coat at about 1759 (5:59 PM). I also advised the staff that [client A] was currently at [hospital] under immediate detention and receiving medical attention for being in the cold for a period of time without proper attire. Over the past year officers have responded to this group</p>			
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	<p>home numerous times to assist in locating special needs residents who have left the house. Due to the fact that [client A], a special needs resident who at the time was under the direct supervision and care of the group home staff was able to exit the house into poor weather conditions for several hours prior to group home staff realizing he was gone (sic)."</p> <p>-Summary of Internal Investigation Report (SIIR) dated 1/22/14 interview notes with HM #1 indicated:</p> <p>-"[Client A's] IDT had discussed his risk of elopement, but there is currently no plan in place to address this."</p> <p>-"... left the group home just before 5:00 PM on 1/9/14. Said she received a call approximately 10 minutes later informing her [client A] had vacated the home, but was stopped near the van and had returned to the group home. Said she was informed that the staff was going to hide [client A's] coat and shoes."</p> <p>The 1/22/14 SIIR's interview notes with staff #1 indicated:</p> <p>-"Said [staff #2] took [client A's] shoes and coat from him in an attempt to keep him from vacating the home again."</p>			

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	<p>The 1/22/14 SIIR's interview notes with staff #2 indicated:</p> <p>-"Said he used his own 'discretion' in taking [client A's] coat and shoes thinking he would not leave if he did not have these items."</p> <p>The 1/22/14 SIIR's conclusion indicated, "Evidence supports staff are not properly trained to work with [client A]. Evidence supports staff used what they thought was their best judgement in an attempt to keep [client A] from vacating."</p> <p>-Recommendations resulting from an Investigation (RRI) form dated 1/9/14 included the recommendation to convene the IDT to develop client A's BSP (Behavior Support Plan), RMAP (Risk Management Assessment Plan), ISP (Individual Support Plan), CST (Client Specific Training)...."</p> <p>2. BDDS report dated 2/19/14, 11:15 AM indicated, "[Client A] reported to his supervisor that he was not feeling well. [Client A] reported that he had an upset stomach and staff discussed to find that he was reporting that it was due to noise. Staff discussed and [client A] wanted to go outside. Staff walked outside with [client A] then went to call his residential staff to discuss. [Day service] staff called</p>						

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	<p>[RM #1 (Residential Manager)] and left a message immediately returning to were [client A] was. [Client A] was no longer there and staff began an immediate search of the area. [Client A] could not be found so staff began to search the neighborhood and called residential provider back. Residential staff discovered that [client A] was at the [community] library and went to pick him up at approximately 1:00 PM. Plan to resolve: Team will meet to discuss appropriate safety parameters." The 2/19/14 BDDS report indicated client A was out of supervision from 11:15 AM through 1:00 PM. The 2/19/14 BDDS report indicated day service staff left client A outside unattended.</p> <p>-SIIR dated 2/26/14 indicated day program staff had allowed client A to go outside while at the day program unattended. The 2/26/14 SIIR interview with DPM (Day Program Manager) #1 indicated "... he forgot that [client A] was an elopement risk."</p> <p>-Recommendations resulting from an Investigation form dated 2/20/14 included the following recommendations regarding client A's 2/29/14 elopement "Ensure day program has a copy and are trained of [client A's] BSP. Complete an ISP and RMAP and train staff to complete client</p>						

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	<p>specific training."</p> <p>The facility's staff training log was reviewed on 3/10/14 at 9:05 AM. Client A's 1/29/14 Inservice training report did not indicate documentation of facility staff being trained regarding client A's 1/29/14 ISP and/or RMAP.</p> <p>Client A's record was reviewed on 3/6/14 at 11:06 AM. Client A's BSP dated 1/20/14 indicated the following:</p> <p>- "Due to the frequent attempts to elope/vacate, [client A] is to remain in a 'line of sight' perimeter at all times during waking hours."</p> <p>- "The staff should pay special attention to [client A's] mood and behavior. If the staff member suspects [client A] is getting agitated and his behavior may escalate, attempt to redirect [client A] to an activity in an area... that does not have direct access to outside.... The one-on-one staff should also pay special attention to [client A] when is near any door leading to the outside.... The staff should always be closest to the door when in a room with [client A]."</p> <p>- "Component 1: Vacating. Warning Signs/Proactive-Preventative: Staff should be aware of [client A's]</p>			
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	<p>whereabouts at all times. In inclement weather, keep protective clothing for staff and [client A] near the door so that it is easily available if [client A] exits the home. [Client A] also has an alarm attached to his door to alert staff when he has left his room."</p> <p>-"Responding to Elopement: Staff should implement the following steps regarding vacating:</p> <ol style="list-style-type: none"> 1. If staff suspects [client A] is getting agitated and his behavior may escalate, attempt to redirect [client A] to an activity in another area of the house that does not have direct access to outside the home. 2. If staff observes [client A] attempting to leave, prompt him to stop and remain within the program area. If [client A] does a requested, resume the ongoing activity with no further comment. 3. If staff observes [client A] attempting to leave and he ignores the prompt to stop, the staff should use agency approved physical intervention techniques to prevent [client A] from leaving home. 4. If staff is unable to stop [client A] and he leaves anyway, the one-on-one staff 						

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	<p>member responsible for his program must exit with him and stay with him to protect him from danger. Due to [client A's] fast nature, the location of his home, and his history of property damage when he vacates, the one-on-one staff member should use agency approved physical intervention techniques to stop [client A]. Staff should attempt to keep [client A] away form the road, other homes, property, and/or vehicles.</p> <p>5a. If necessary, and if additional staff are available, a second staff member should exit the home and assist the one-on-one staff.</p> <p>5b. If [client A] and the one-on-one staff are in eyesight, the additional staff member should assist on foot.</p> <p>5c. If [client A] and the one-on-one staff are out of eyesight, the additional staff should use the van to find [client A] and his one-on-one staff to assist.</p> <p>5d. If at any time [client A] has vacated and two or more staff are available and in [client A's] reach they should use agency approved physical intervention techniques to stop [client A].</p> <p>6. When [client A] is contained, escort him to a safe location and keep him under</p>				

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	<p>observation until you are sure he will not vacate again. Limit conversation with [client A] for ten minutes.</p> <p>7. If you are unable to catch up with [client A] after ten minutes, contact the on-call supervisor for further instructions.</p> <p>8. If you do not see [client A] leave the area, contact the on-call supervisor as soon as you notice he is gone and initiate search procedures; (If at any point [client A] is no longer in eyesight, immediately contact 911 and the on-call supervisor."</p> <p>Client A's 2/24/14 IDT meeting form indicated the facility IDT had convened to discuss client A's 2/19/14 elopement from his day service provider. The 2/24/14 IDT's recommendations included "Forward over new BSP to [day program]."</p> <p>AD (Area Director) #1 was interviewed on 3/6/14 at 12:01 PM. AD #1 indicated the facility had not provided the day program with a copy of client A's 1/20/14 BSP. AD #1 indicated the day program staff had not been trained regarding client A's 1/20/14 BSP. AD #1 indicated the day program staff should be trained on client A's BSP. AD #1 indicated client A's 1/20/14 BSP should be implemented at client A's day program.</p>						

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	<p>3. BDDS report dated 10/22/13 indicated, "[Client B] was walking around the house saying 'Call the police, I'm ready to go to jail', [HM #1] was there and called the police just so they could come talk to [client B] to try to calm him down. [Client B] eloped, but he wears a Project Lifesaver bracelet on his ankle and police were able to locate him. He was gone approximately an hour." The 10/22/13 BDDS report indicated, "Plan to resolve: [Client B] had some cuts and bruises and was taken to [hospital's] individual detention area for evaluation. At about 1:30 AM, [hospital] called and [HM #1] picked up [client B] and returned to the group home. [Client B] resumed his normal routine and went to day placement this morning. Vacating is in [client B's] BSP. Continue to follow BSP and monitor for health and safety." The 10/22/13 BDDS report did not indicate documentation of facility staff's attempts to redirect client B to an activity in another area of the house that does not have direct access to the outside of the home, prompt client B to remain within the program area, or attempt to utilize agency approved physical intervention techniques to respond to client B's elopement behavior. The 10/22/13 BDDS report did not indicate documentation of facility staff exiting the group home to</p>			
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	<p>protect client B from danger or of facility staff utilizing additional staff with the facility van to locate client B.</p> <p>4. BDDS report dated 1/21/14 indicated, "Staff (unspecified) noticed [client B] trying to elope out his bedroom window. [Client B] was able to get out of his bedroom window and staff was able to follow him and keep him insight. Staff notified [HM #1 (Home Manager)] and followed elopement protocol and called the police for assistance. Staff was able to get [client B] to go back home and follow directives. Police came out to group home and talked with [client B] about safety." The 1/21/14 BDDS report indicated, "Plan to Resolve: Staff will continue to monitor [client B's] health and safety." The 1/21/14 BDDS report did not indicate documentation of facility staff's use or attempted use of agency approved physical intervention techniques. The 1/21/14 BDDS report did not indicate documentation of client B evading facility staff's supervision during the elopement incident or client B attempting to enter a home other than the group home.</p> <p>5. BDDS report dated 3/2/14 indicated, "On 3/2/14, [client B] eloped from his group home through a window. Staff noticed him missing and went looking for</p>			

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	<p>him quickly. Staff found [client B] hiding in the bushes nearby the group home. [Client B] refused to come back to the group home with staff. Staff called the police and they were able to get [client B] to go back to the group home." The 3/2/14 BDDS report indicated, "Plan to resolve: Staff will monitor [client B] for his health and safety. Staff will follow [client B's] BSP for elopement." The 3/2/14 BDDS report did not indicate documentation of facility staff's use or attempted use of agency approved physical intervention techniques. The 3/2/14 BDDS report did not indicate documentation of client B evading facility staff's supervision during the elopement incident or client B attempting to enter a home other than the group home.</p> <p>Client B's record was reviewed on 3/7/14 at 2:42 PM. Client B's BSP dated 3/10/13 indicated the following:</p> <p>-"Component 1: Vacating. Warning Signs/Proactive-Preventative: Staff should be aware of [client B's] whereabouts at all times. In inclement weather, keep protective clothing for staff and [client B] near the door so that it is easily available if [client B] exits the home. [Client B] also has an alarm attached to his door to alert staff when he</p>			
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	<p>has left his room."</p> <p>- "Responding to Elopement: Staff should implement the following steps regarding vacating:</p> <ol style="list-style-type: none"> 1. If staff suspects [client B] is getting agitated and his behavior may escalate, attempt to redirect [client B] to an activity in another area of the house that doesn't have direct access to outside the home. 2. If staff observes [client B] attempting to leave, prompt him to stop and remain within the program area. If [client B] does as requested, resume the ongoing activity with no further comment. 3. If staff observes [client B] attempting to leave and he ignores the prompt to stop, the staff should use agency approved physical intervention techniques to prevent [client B] from leaving home. 4. If staff is unable to stop [client B] and he leaves anyway, the one-on-one staff member responsible for his program must exit with him and stay with him to protect him from danger. Due to [client B's] fast nature, the location of his home, and his history of property damage when he vacates, the one-on-one staff member 				

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	<p>should use agency approved physical intervention techniques to stop [client B]. Staff should attempt to keep [client B] away from the road, other homes, property, and/or vehicles.</p> <p>5a. If necessary, and if additional staff are available, a second staff member should exit the home and assist the one-on-one staff.</p> <p>5b. If [client B] and the one-on-one staff are in eyesight, the additional staff member should assist on foot.</p> <p>5c. If [client B] and the one-on-one staff are out of eyesight, the additional staff should use the van to find [client B] and his one-on-one staff to assist.</p> <p>5d. If at any time [client B] has vacated and two or more staff are available and in [client B's] reach they should use agency approved physical intervention techniques to stop [client B].</p> <p>6. When [client B] is contained, escort him to a safe location and keep him under observation until you are sure he will not vacate again. Limit conversation with [client B] for ten minutes.</p> <p>7. If you are unable to catch up with [client B] after ten minutes, contact the</p>				

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	<p>on-call supervisor for further instructions.</p> <p>8. If you do not see [client B] leave the area, contact the on-call supervisor as soon as you notice he is gone and initiate search procedures; (If at any point [client B] is no longer in eyesight, immediately contact 911 and the on-call supervisor."</p> <p>AD #1 was interviewed on 3/6/14 at 12:01 PM. AD #1 indicated the indicated staff should attempt to redirect client B to an activity in another area of the house that does not have direct access to the outside of the home, prompt client B to remain within the program area, or attempt to utilize agency approved physical intervention techniques to respond to client B's elopement behavior, staff should exit the group home/follow client B to protect him from danger and staff should utilize additional staff with the facility van to locate client B before calling 911 for assistance. AD #1 indicated staff did not implement client B's BSP during client B's 10/22/13, 1/21/14 and 3/2/14 incidents of elopement. AD #1 indicated facility staff had not been retrained regarding implementation of client B's BSP to prevent or respond to incidents of client B's elopement behaviors.</p> <p>This federal tag relates to complaint</p>						

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