

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G789	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/24/2014
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NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3770 W 80 N KOKOMO, IN 46901
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W000000	<p>This visit was for the pre-determined full recertification and state licensure survey. This visit included the investigations of complaint #IN00159938 and complaint #IN00160782.</p> <p>Complaint #IN00159938: SUBSTANTIATED, Federal and State deficiencies related to the allegations were cited at W122, W153, and W249.</p> <p>Complaint #IN00160782: SUBSTANTIATED, Federal and State deficiencies related to the allegation were cited at W104, W122, W140, W149, and W153.</p> <p>Dates of Survey: 12/16, 12/17, 12/18, 12/19, 12/22, 12/23, and 12/24/2014.</p> <p>Provider Number: 15G789 AIM Number: 201012970 Facility Number: 012485</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed January 2,</p>	W000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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W000104	<p>2015 by Dotty Walton, QIDP.</p> <p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review, and interview, for 4 of 4 sampled clients (clients A, B, C, and D) and four (4) additional clients (clients E, F, G, and H), the governing body failed to exercise operating direction over the facility to ensure routine maintenance was completed for the worn and damaged hardwood floors in the living room, front entry, and dining room and the bath tub in clients C and F's shared bedroom.</p> <p>The governing body failed to provide oversight to ensure clients A, B, and G were not victims of financial exploitation by a facility staff and to ensure the staff reconciled a complete accounting for client A, B, C, D, E, F, G, and H's personal funds.</p> <p>Findings include:</p> <p>1. On 12/16/14 from 4:20pm until 6:20pm, and on 12/17/14 from 5:45am until 8:15am, observations and interviews were conducted at clients A, B, C, D, E, F, G, and H's group home. During both the observation periods, the front entry,</p>	W000104	<p>Toensure routine maintenance and proper operating direction over the group home,the following corrective action(s) will be implemented:</p> <p>1) TheDirector of Safety and Maintenance surveyed the group home on December 22, 2014.He is currently securing bids to refinish the hardwood flooring throughout thehome as well as bids for replacement flooring such as laminate. Additionally,he is also securing various quotes for the bath tub in the clients' bedroom. Heis securing bids to repair the leaking pipes and drains; bids to make the bathtub ADA accessible, and additional bids for removing the tub and converting thebathroom into a walk-in shower. To datewe have received a full quote to refinish the floors and a partial quote forthe bath tub. Once all bids</p>	01/23/2015			

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	<p>living room, and dining room hardwood floors were worn, the brown colored wood were faded, and areas of the wood finish was smoother in some areas than others. During both observation periods, clients A, B, C, D, E, F, G, and H walked throughout the group home to access the front entry, living room, and dining room areas. On 12/17/14 at 6:10am, Group Home Staff (GHS) #1 indicated the dining room, living room, and front entry hardwood floors were worn and faded. During both observation periods, client C and F's shared bedroom had a bathroom with a hot tub. On 12/17/14 at 7:45am, clients C and F stated the hot tub "leaked water" and they could not use their tub. At 7:45am, client C stated the hot tub "needs fixed. I'd like to use it." At 7:45am, client H stated he would like to use the hot tub. Client F stated he had lived in the group home "over a year" and had not been able to use the hot tub.</p> <p>On 12/18/14 at 10:10am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the worn hardwood floors were discolored and needed repaired. The QIDP indicated she was unaware the hot tub in client C and F's shared bathroom leaked and needed repaired.</p>		<p>have been obtained, the administrative team will determine the best course of action based on cost analysis and client needs.</p> <p>To ensure that client funds are properly appropriated and that clients are not victims of financial exploitation, the following corrective action(s) will be implemented:</p> <p>1) The Residential House Manager will review all client financial records on a weekly basis to ensure proper appropriation and spending of funds, as well as to ensure an accurate account of funds available and spent. If funds are misappropriated or unaccounted for, the Residential House Manager will report it immediately to the Director and Vice President of Residential Services. The Director and Vice President will immediately launch an investigation to determine the discrepancies and the appropriate course of action for the staff involved. All allegations will be reported as outlined in mandated</p>				

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	<p>2. On 12/16/14 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and included the following incidents of financial exploitation for clients A, B, and G:</p> <p>-A 12/8/14 BDDS report for an incident on 12/8/14 at 8:00am for clients A, B, and G, indicated the Group Home Staff (GHS) reported to the Residential Home Manager that client A had \$50.00, client B had \$31.00, client G had \$30.00 "missing out of [clients A, B, and G's names] money pouch(es)" and an investigation was initiated.</p> <p>On 12/18/14 at 10:10am, a review of client A, B, and G's 10/2014, 11/2014, and 12/2014 "Consumer Ledger(s)" and clients A, B, C, D, E, F, G, and H's 10/2014, 11/2014, and 12/2014 "Main Ledger(s)" was conducted and indicated the following:</p> <p>-The 12/2014 "Main Ledger(s)" were reviewed and indicated one facility staff reviewed and reconciled clients A, B, C, D, E, F, G, and H's cash on hand to the ledger on 12/17/14, 12/16/14, 12/12/14, 12/11/14, 12/6/14, and 12/5/14. The 12/5/14 and 12/6/14 "Main Ledger" indicated the following cash balances: client A was \$55.00, client B was \$31.61,</p>		<p>reporting guidelines.</p> <p>2) Administration now requires all staff on shift to count all consumer "money packs" at the beginning and end of scheduled shifts in the presence of another staff member.</p> <p>3) The previous "money box" has been replaced with a new one that locks and the key is maintained by the designated "key holder" on shift as assigned by the Residential House Manager.</p> <p>4) On December 16, 2014, all staff located at 3770 North 80 West (Sycamore group home) have been retrained on the departmental money and receipt policies and procedures.</p>				

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	<p>and client G was \$33.00. The 12/11/14 "Main Ledger" indicated beginning cash balances for client A zero, client B zero, and client G was zero.</p> <p>-Client A's 12/2014, 11/2014, and 10/2014 ledgers did not indicate two facility staff reviewed and counted client A's cash on hand for each shift of personnel. Client A's 11/2014 ledger indicated an undated entry after 12/5/14 entry "missing \$55.00 will be refunded by Bona Vista." Client A's 12/10/14 "Purchase Requisition indicated "\$55.00 this is a reimbursement receipt for money that was stolen from the consumer."</p> <p>-Client B's 12/2014, 11/2014, and 10/2014 ledgers did not indicate two facility staff reviewed and counted client B's cash on hand for each shift of personnel. Client B's 11/2014 ledger indicated an undated entry after 12/5/14 entry "missing \$31.00 will be refunded by Bona Vista." Client B's 12/10/14 "Purchase Requisition" indicated "\$31.00 this is a reimbursement receipt for money that was stolen from the consumer."</p> <p>-Client G's 12/2014, 11/2014, and 10/2014 ledgers did not indicate two facility staff reviewed and counted client G's cash on hand for each shift of personnel. Client G's 11/2014 ledger</p>						

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	<p>indicated an undated entry after 12/5/14 entry "missing \$30.00 will be refunded by Bona Vista." Client G's 12/10/14 "Purchase Requisition" indicated "\$30.00 this is a reimbursement receipt for money that was stolen from the consumer."</p> <p>On 12/18/14 at 10:10am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional), the Group Home Manager (GHM), and the VPRS (Vice President of Residential Services). The GHM stated client A, B, and G's personal funds were "believed to be stolen" from their money pouches at the group home. The GHM and the VPRS both indicated based on the investigation so far the one staff who was being shown by a second staff the procedure for counting each client's money every shift were in the office together. The two staff counted out five of eight (5 of 8) client money pouches and reconciled the counted money to each clients' ledger (the main ledger and the consumer ledger). The GHM indicated the second staff had excused herself for another matter at the group home and left the one remaining staff in the office alone with the three (3) remaining clients money pouches to count (clients A, B, and G). The staff finished their shifts of work. The GHM indicated the policy and procedure was</p>						

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	<p>for two staff to count and reconcile the funds each shift of personnel. The GHM indicated no one counted the clients money again after 12/6/14 until 12/8/14. The GHM stated "the key for the money box was missing also." The GHM stated the staff person who counted client A, B, and G's money on 12/6/14 was a "no show" for work and had not returned to work since the incident. The GHM indicated she obtained a new money box to replace the old box since the key was missing. The GHM indicated the clients money was counted on 12/11/14. The GHM stated the policy and procedure "was always to have two (2) staff count the money each" shift of personnel. The GHM indicated the staff did not follow the policy and procedure. The GHM indicated the staff were not retrained until 12/17/14 for following the policy and procedure. The GHM indicated no one reported the money box as missing until Monday 12/8/14 when the box was last seen on 12/6/14.</p> <p>On 12/18/14 at 1:00pm, a review of the 10/2011 "Money and Receipt Procedure" indicated "...No more than \$20.00 per consumer will be kept in the cash box at any given time...Staff will count the money that is in the cash box at each shift change. The amount in the cash box will be documented on the main ledger.</p>			

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	<p>Another staff on duty will count the money in the cash box to verify and document as witness...Two staff will again document that money and receipts have been returned...Any discrepancies, other than addition/subtraction errors will be reported immediately to the house manager and then the Vice President of Residential Services...."</p> <p>On 12/24/14 at 10:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Vice President of Residential Services (VPRS) was conducted. The QIDP and the VPRS both indicated the facility staff failed to immediately report that client A, B, and G's money was missing. The VPRS indicated the facility followed the BDDS reporting policy and procedure for immediately reporting allegations of financial exploitation which included missing money. The VPRS indicated the governing body failed to provide oversight to ensure clients A, B, and G were not victims of financial exploitation.</p> <p>This federal tag relates to complaint #IN00160782.</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 observation, interview, and record review, the facility failed to meet the Condition of Participation: Client Protections for 4 of 4 sampled clients (clients A, B, C, and D) and 4 additional clients (clients E, F, G, and H). The facility failed to implement their policy and procedures to protect clients A, B, C, D, E, F, G, and H from the abuse, neglect, mistreatment and/or financial exploitation, failed to ensure staff supervision, failed to immediately report incidents of abuse, neglect, mistreatment, and/or financial exploitation, and failed to ensure client plans were developed to ensure client rights.</p> <p>Findings include:</p> <p>1. Please refer to W149. The facility neglected to implement the agency's policy and procedure to prevent abuse, neglect, and/or mistreatment by neglecting to ensure implementation of the agency's policies and procedures for abuse, neglect, and/or mistreatment for clients A, B, C, D, E, F, G, and H, finances for clients A, B, C, D, E, F, G, and H, and neglected to ensure staff supervision of clients B, C, and F based on their identified needs for 6 of 32</p>	W000122	<p>Toensure that established agency policies and procedures for abuse, neglect, andmistreatment of clients are implemented and executed as written, the followingcorrective action(s) will be implemented:</p> <p>1) Allstaff located at 3770 North 80 West (Sycamore group home) will be retrained onthe agency abuse and neglect policy. Completed Record of Trainings will beobtained and submitted upon completion of training. <i>Refer to Appendix A forRecord of Training forms to be used.</i></p> <p>2) TheResidential House Manager will review all client financial records on a weeklybasis to ensure proper appropriation and spending of funds, as well as toensure an accurate account of funds available and spent. If funds aremisappropriated or unaccounted for, the Residential House Manager will reportit immediately to the Director and Vice President of</p>	01/23/2015			

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	<p>incidents reviewed for 8 of 8 clients (clients A, B, C, D, E, F, G, and H).</p> <p>2. Please refer to W153. The facility failed to immediately report to the administrator and to BDDS in accordance with State Law for allegations of financial exploitation by the facility staff and for client D's repeated falls with injuries for 2 of 32 BDDS (Bureau of Developmental Disabilities Services) reports reviewed which included 1 allegation for clients A, B, and G's financial exploitation and for 1 report of 3 incidents of client D's repeated falls with injuries.</p> <p>3. Please refer to W159. The Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate, and monitor client F's active treatment plans to ensure design and delivery which provided client F with appropriate interventions in client F's Individual Support Plan (ISP) and Behavior Support Plan (BSP) to ensure dignity, protection of his client rights, and to ensure the plans effectively addressed client F's needed supports based on his behavioral need for 1 of 8 (client F).</p> <p>4. Please refer to W125. The facility failed to ensure client B had a legally sanctioned representative to assist him</p>		<p>Residential Services. The Director and Vice President will immediately launch an investigation to determine the discrepancies and the appropriate course of action for the staff involved. All allegations will be reported as outlined in mandated reporting guidelines.</p> <p>3) Administration now requires all staff on shift to count all consumer "money packs" at the beginning and end of scheduled shifts in the presence of another staff member.</p> <p>4) The previous "money box" has been replaced with a new one that locks and the key is maintained by the designated "key holder" on shift as assigned by the Residential House Manager.</p> <p>5) On December 16, 2014, all staff located at 3770 North 80 West (Sycamore group home) have been retrained on the departmental money and receipt policies and procedures.</p> <p>6) The QIDP will revise individual plans for all clients residing in the home to ensure</p>				

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	<p>with his medical and financial needs per his assessments for 1 of 4 sampled clients (client B) who lived in the group home.</p> <p>5. Please refer to W140. The facility failed to ensure the facility implemented its written policy in regard to client finances to ensure accountability of clients' funds for clients A, B, and G for 2 of 4 sampled clients (A and B) and 1 additional client (client G).</p> <p>This federal tag relates to complaint #IN00159938.</p> <p>This federal tag relates to complaint #IN00160782.</p> <p>9-3-2(a)</p>		<p>needs are met. All staff located at 3370 North 80 West (Sycamore grouphome) will be retrained on all revised individual plans. A record of trainingform will be completed by all staff members when trainings are finalized.</p> <p>7) Toensure proper monitoring and compliance, the Residential House Manager and QIDPwill make frequent unannounced stops to the group home during various shifts.If staff have failed to implement individual plans as directed, the respectivestaff will be retrained on individual plans and if warranted receiveappropriate disciplinary action as outlined in the agency personnel policiesand procedures.</p> <p>a. Toensure that established agency policies and procedures for incident reportingis being implemented and executed as written, the following corrective action(s)will be implemented:</p> <p>1) Allstaff located at 3770 North 80 West (Sycamore group home) will be re-trained</p>		

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			<p>onthe agency Personnel Policies and Procedures, Policy III:13: IncidentReporting. Completed Record of Trainings will be obtained and submitted uponcompletion of training. <i>Refer to Appendix B for Record of Trainingform to be used.</i></p> <p>Toensure that established agency policies and procedures for incident reportings is being implemented and executed as written, the following corrective action(s)will be implemented:</p> <p>1) TheQIDP will revise individual plans for Client F to ensure appropriateinterventions and that all needs are effectively met to best benefit him. Allstaff located at 3370 North 80 West (Sycamore group home) will be retrained on ClientF's revised individual plans. A record of training form will be completed byall staff members when trainings are finalized.</p> <p>Toensure that client #1 has a legally sanctioned</p>		

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			<p>representative to assist himwith his medical and financial needs per his assessment, the followingcorrective action(s) will be implemented:</p> <p>1) TheResidential Director and QIDP will work with existing agencies within our communityand other communities to obtain a valid and qualified advocate for Client #1 toassist him with decision making in regards to medical care, financialobligations, and any other pertinent decisions relating to his care andwell-being.</p> <p>Toensure that established agency policies and procedures for client finances arebeing implemented and executed as written, the following corrective action(s)will be implemented:</p> <p>1) TheResidential House Manager will review all client financial records on a weeklybasis to ensure proper appropriation and spending of funds, as well as toensure an accurate account of funds</p>	

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W000125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow		available and spent. If funds are misappropriated or unaccounted for, the Residential House Manager will report it immediately to the Director and Vice President of Residential Services. The Director and Vice President will immediately launch an investigation to determine the discrepancies and the appropriate course of action for the staff involved. All allegations will be reported as outlined in mandated reporting guidelines. 2) Administration now requires all staff on shift to count all consumer "money packs" at the beginning and end of scheduled shifts in the presence of another staff member. 3) On December 16, 2014, all staff located at 3770 North 80 West (Sycamore group home) have been retrained on the departmental money and receipt policies and procedures.		

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	<p>and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on record review and interview, for 1 of 4 sampled clients (client B) who lived in the group home, the facility failed to ensure client B had a legally sanctioned representative to assist him with his medical and financial needs per his assessments.</p> <p>Findings include:</p> <p>On 12/16/14 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and indicated the following for client B's AWOL (Absence without Leave) behavior.</p> <p>-A 9/11/14 BDDS report for an incident on 9/10/14 at 6:05pm, indicated "Around 6:08pm, a neighbor notified staff that [client B] was walking down the road. Staff were unaware that [client B] had left the home. They immediately began to look for him." At 6:45pm, client B was located "about a mile away from the home, sitting on the corner of 400 West and State Road 22." The report indicated client B was not injured "but wet from the rain." The report indicated client B was "upset over some food items." The</p>	W000125	<p>Toensure that client #1 has a legally sanctioned representative to assist himwith his medical and financial needs per his assessment, the followingcorrective action(s) will be implemented: 1) TheResidential Director and QIDP will work with existing agencies within ourcommunity and other communities to obtain a valid and qualified advocate forClient #1 to assist him with decision making in regards to medical care,financial obligations, and any other pertinent decisions relating to his careand well-being. a. "Wereany other clients affected by the deficient practice?" Yes. There are four additionalclients within the home that do not have a legally sanctioned representative toassist with financial and medical decisions. b. "Howwill the facility monitor to ensure compliance?" To ensure that all clients residingin the group home setting have appropriate legally sanctioned representativesto assist with medical and financial decisions, the inter-disciplinary teamwill review each client's status with a guardian or health care representativeon an annual basis or as needed if changes in</p>	02/01/2015	

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	<p>report indicated client B "had an elopement plan in place and the home has window and door alarms. These alarms will be checked to ensure that they are in proper working conditions."</p> <p>-The 9/11/14 Investigation for client B's 9/10/14 incident indicated client B eloped from the group home "without staffs (sic) knowledge" after becoming "upset at staff when he was asked to clean up his dishes from dinner so he went to his room and stayed there for some time." The investigation indicated "the allegations of neglect are unsubstantiated. Consumer [client B] has a history of elopement on a regular basis." The investigation indicated two (2) staff were on duty with eight (8) clients in the group home.</p> <p>-GHS (Group Home Staff) #8's 9/11/14 witness statement indicated two staff were at the group home during client B's 9/10/14 elopement incident. GHS #8 stated "I think we kinda (sic) realized at the same time. I went into [client B's] bedroom...I realized [client B] wasn't in his bed. [GHS #7] came in and said some guy came and told her one of our consumers was walking down the road. By the time I got to tell [client H] that I needed to check on someone, [GHS #7] was coming in saying some guy was</p>		<p>circumstances requires that theagency assist in obtaining a new or additional representative to assistindividual clients.</p>		

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	<p>telling [client H]." GHS #8 stated it was "about 6:10 (no am or pm was indicated)" and GHS #7 was pulling out of the driveway in the van to go look for client B. GHS #8 indicated she called the police to report client B missing after the Group Home Manager called to tell her to call the police.</p> <p>Client B's record was reviewed on 12/18/14 at 2:10pm. Client B's 5/1/14 ISP (Individual Support Plan) and 5/2014 BSP (Behavior Support Plan) both indicated client B had targeted behaviors of Elopement. Client B's plans indicated staff were to provide twenty-four hour supervision. Client B's diagnoses included but were not limited to: Major Depression, Seizure Disorder, Cerebral Palsy, and Pain Disorder. Client B's 5/1/14 "Elopement Plan" indicated when client B elopes "it is because he (becomes) upset...staff will be aware of this and keep [client B] within line of sight at all times...[client B] requires 24 hour awake staff, and must remain within line of sight any time that he is in the community...." Client B's Elopement Plan indicated he was at risk for falls, seizures, and for his safety. Client B's 5/1/14 "Capacity for Independence/Informed Consent" assessment indicated client B did not recognize danger when upset, required</p>				

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	<p>supervision in the community, was not independent with his finances and/or medical care, and did not have independent pedestrian safety skills. Client B's assessment indicated the agency staff assisted client B to make decisions of informed consent. Client B's Capacity for Independence assessment, ISP, and BSP indicated the following areas were reviewed: personal finances, housing, personal safety, medical, behavioral, civil rights, and communication. Client B's record indicated he did not have a legally sanctioned representative and did not have a contact person outside the agency to assist client B to understand his rights.</p> <p>On 12/24/14 at 10:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Vice President of Residential Services (VPRS) was conducted. The QIDP and the VPRS both indicated client B was not independent in the community and needed staff to supervise him while in the community. The QIDP indicated client B's Elopement plan indicated staff were to have kept client B within line of sight when he becomes upset to prevent client B's AWOL/Elopement behavior and staff did not implement client B's plans on 9/10/14. The QIDP indicated client B's Informed Consent assessment, ISP, and</p>			

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W000140	<p>BSP did indicate he needed assistance of the facility staff to advocate for him and to assist him with the decision making process for medical care and with his finances. The QIDP indicated client B did not have a legally sanctioned representative at this time. The QIDP indicated client B did not understand his rights, medical care, or finances and benefited from a facility advocate to assist to explain these to client B.</p> <p>9-3-2(a)</p> <p>483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview, for 2 of 4 sampled clients (A and B) and 1 additional client (client G), the facility failed to ensure the facility implemented its written policy in regard to client finances to ensure accountability of clients' funds for clients A, B, and G.</p> <p>Findings include:</p> <p>On 12/16/14 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and included the following</p>	W000140	<p>Toensure that established agency policies and procedures for client finances arebeing implemented and executed as written, the following corrective action(s)will be implemented:</p> <p>1) TheResidential House Manager will review all client financial records on a weeklybasis to ensure proper appropriation and spending of funds, as well as toensure an</p>	01/23/2015

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	<p>incidents of financial exploitation for clients A, B, and G:</p> <p>-A 12/8/14 BDDS report for an incident on 12/8/14 at 8:00am for clients A, B, and G, indicated the Group Home Staff (GHS) reported to the Residential Home Manager that client A had \$50.00, client B had \$31.00, client G had \$30.00 "missing out of [clients A, B, and G's names] money pouch(es)" and an investigation was initiated.</p> <p>On 12/18/14 at 10:10am, a review of client A, B, and G's 10/2014, 11/2014, and 12/2014 "Consumer Ledger(s)" and clients A, B, C, D, E, F, G, and H's 10/2014, 11/2014, and 12/2014 "Main Ledger(s)" were conducted and indicated the following:</p> <p>-The 12/2014 "Main Ledger(s)" were reviewed and indicated one facility staff reviewed and reconciled clients A, B, C, D, E, F, G, and H's cash on hand to the ledger on 12/17/14, 12/16/14, 12/12/14, 12/11/14, 12/6/14, and 12/5/14. The 12/5/14 and 12/6/14 "Main Ledger" indicated the following cash balances for: client A was \$55.00, client B was \$31.61, and client G was \$33.00. The 12/11/14 "Main Ledger" indicated beginning cash balances for client A zero, client B zero, and client G was zero.</p>		<p>accurate account of funds available and spent. If funds are misappropriated or unaccounted for, the Residential House Manager will report it immediately to the Director and Vice President of Residential Services. The Director and Vice President will immediately launch an investigation to determine the discrepancies and the appropriate course of action for the staff involved. All allegations will be reported as outlined in mandated reporting guidelines.</p> <p>2) Administration now requires all staff on shift to count all consumer "money packs" at the beginning and end of scheduled shifts in the presence of another staff member.</p> <p>3) On December 16, 2014, all staff located at 3770 North 80 West (Sycamore group home) have been retrained on the departmental money and receipt policies and procedures.</p>				

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	<p>-Client A's 12/2014, 11/2014, and 10/2014 ledgers did not indicate two facility staff reviewed and counted client A's cash on hand for each shift of personnel. Client A's 11/2014 ledger indicated an undated entry after 12/5/14 entry "missing \$55.00 will be refunded by Bona Vista." Client A's 12/10/14 "Purchase Requisition" indicated "\$55.00 this is a reimbursement receipt for money that was stolen from the consumer."</p> <p>-Client B's 12/2014, 11/2014, and 10/2014 ledgers did not indicate two facility staff reviewed and counted client B's cash on hand for each shift of personnel. Client B's 11/2014 ledger indicated an undated entry after 12/5/14 entry "missing \$31.00 will be refunded by Bona Vista." Client B's 12/10/14 "Purchase Requisition" indicated "\$31.00 this is a reimbursement receipt for money that was stolen from the consumer."</p> <p>-Client G's 12/2014, 11/2014, and 10/2014 ledgers did not indicate two facility staff reviewed and counted client G's cash on hand for each shift of personnel. Client G's 11/2014 ledger indicated an undated entry after 12/5/14 entry "missing \$30.00 will be refunded by Bona Vista." Client G's 12/10/14 "Purchase Requisition" indicated "\$30.00</p>			

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	<p>this is a reimbursement receipt for money that was stolen from the consumer."</p> <p>On 12/18/14 at 10:10am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional), the Group Home Manager (GHM), and the VPRS (Vice President of Residential Services). The GHM stated client A, B, and G's personal funds were "believed to be stolen" from their money pouches at the group home. The GHM and the VPRS both indicated based on the investigation so far the one staff who was being shown by a second staff the procedure for counting each client's money every shift were in the office together. The two staff counted out five of eight (5 of 8) client money pouches and reconciled the counted money to each client's ledger (the main ledger and the consumer ledger). The GHM indicated the second staff had excused herself for another matter at the group home and left the one remaining staff in the office alone with the three (3) remaining clients money pouches to count (clients A, B, and G). The staff finished their shifts of work. The GHM indicated the policy and procedure was for two staff to count and reconcile the funds each shift of personnel. The GHM indicated no one counted the clients money again after 12/6/14 until 12/8/14.</p>			

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	<p>The GHM stated "the key for the money box was missing also." The GHM stated the staff person who counted client A, B, and G's money on 12/6/14 was a "no show" for work and had not returned to work since the incident. The GHM indicated she obtained a new money box to replace the old box since the key was missing. The GHM indicated the clients money was counted on 12/11/14. The GHM stated the policy and procedure "was always to have two (2) staff count the money each" shift of personnel. The GHM indicated the staff did not follow the policy and procedure. The GHM indicated the staff were not retrained until 12/17/14 for following the policy and procedure. The GHM indicated no one reported the money box as missing until Monday 12/8/14 when the box was last seen on 12/6/14.</p> <p>On 12/18/14 at 1:00pm, a review of the 10/2011 "Money and Receipt Procedure" indicated "...No more than \$20.00 per consumer will be kept in the cash box at any given time...Staff will count the money that is in the cash box at each shift change. The amount in the cash box will be documented on the main ledger. Another staff on duty will count the money in the cash box to verify and document as witness...Two staff will again document that money and receipts</p>						

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W000149	<p>have been returned...Any discrepancies, other than addition/subtraction errors will be reported immediately to the house manager and then the Vice President of Residential Services..."</p> <p>On 12/24/14 at 10:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Vice President of Residential Services (VPRS) was conducted. The QIDP and the VPRS both indicated the facility staff neglected to immediately report that client A, B, and G's money was missing. The VPRS indicated the facility followed the BDDS reporting policy and procedure for immediately reporting allegations of financial exploitation which included missing money. The VPRS indicated the facility neglected to ensure clients A, B, and G were not victims of financial exploitation.</p> <p>This federal tag relates to complaint #IN00160782.</p> <p>9-3-2(a)</p> <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,</p>	W000149	Toensure that established	01/23/2015	

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	<p>for 6 of 32 incidents reviewed for 8 of 8 clients (clients A, B, C, D, E, F, G, and H), the facility neglected to implement the agency's policy and procedure to prevent abuse, neglect, and/or mistreatment by neglecting to ensure implementation of the agency's policies and procedures for abuse, neglect, and/or mistreatment for clients A, B, C, D, E, F, G, and H, finances for clients A, B, C, D, E, F, G, and H, and neglected to ensure staff supervision of clients B, C, and F based on their identified needs.</p> <p>Findings include:</p> <p>1. On 12/16/14 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and included the following incidents of financial exploitation for clients A, B, and G:</p> <p>-A 12/8/14 BDDS report for an incident on 12/8/14 at 8:00am for clients A, B, and G, indicated the Group Home Staff (GHS) reported to the Residential Home Manager that client A had \$50.00, client B had \$31.00, client G had \$30.00 "missing out of [clients A, B, and G's names] money pouch(es)" and an investigation was initiated.</p> <p>On 12/18/14 at 10:10am, a review of</p>		<p>agency policies and procedures for abuse, neglect, and mistreatment of clients are implemented and executed as written, the following corrective action(s) will be implemented:</p> <p>1) All staff located at 3770 North 80 West (Sycamore group home) will be retrained on the agency abuse and neglect policy. Completed Record of Trainings will be obtained and submitted upon completion of training. <i>Refer to Appendix A for Record of Training forms to be used.</i></p> <p>2) The Residential House Manager will review all client financial records on a weekly basis to ensure proper appropriation and spending of funds, as well as to ensure an accurate account of funds available and spent. If funds are misappropriated or unaccounted for, the Residential House Manager will report it immediately to the Director and Vice President of Residential Services. The Director and Vice President will immediately launch an investigation</p>		

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	<p>clients A, B, and G's 10/2014, 11/2014, and 12/2014 "Consumer Ledger(s)" and clients A, B, C, D, E, F, G, and H's 10/2014, 11/2014, and 12/2014 "Main Ledger(s)" were conducted and indicated the following:</p> <p>-The 12/2014 "Main Ledger(s)" were reviewed and indicated one facility staff reviewed and reconciled clients A, B, C, D, E, F, G, and H's cash on hand to the ledger on 12/17/14, 12/16/14, 12/12/14, 12/11/14, 12/6/14, and 12/5/14. The 12/5/14 and 12/6/14 "Main Ledger" indicated the following cash balances for: client A was \$55.00, client B was \$31.61, and client G was \$33.00. The 12/11/14 "Main Ledger" indicated a beginning cash balance for client A zero, client B zero, and client G was zero.</p> <p>-Client A's 12/2014, 11/2014, and 10/2014 ledgers did not indicate two facility staff reviewed and counted client A's cash on hand for each shift of personnel. Client A's 11/2014 ledger indicated an undated entry after 12/5/14 entry "missing \$55.00 will be refunded by Bona Vista." Client A's 12/10/14 "Purchase Requisition" indicated "\$55.00 this is a reimbursement receipt for money that was stolen from the consumer."</p> <p>-Client B's 12/2014, 11/2014, and</p>		<p>to determine the discrepancies and the appropriate course action for the staff involved. All allegations will be reported as outlined in mandated reporting guidelines.</p> <p>3) Administration now requires all staff on shift to count all consumer "money packs" at the beginning and end of scheduled shifts in the presence of another staff member.</p> <p>4) The previous "money box" has been replaced with a new one that locks and the key is maintained by the designated "key holder" on shift as assigned by the Residential House Manager.</p> <p>5) On December 16, 2014, all staff located at 3770 North 80 West (Sycamore group home) have been retrained on the departmental money and receipt policies and procedures.</p> <p>6) The QIDP will revise individual plans for all clients residing in the home to ensure needs are met. All staff located at 3370 North 80 West (Sycamore group home) will be retrained on all revised</p>				

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	<p>10/2014 ledgers did not indicate two facility staff reviewed and counted client B's cash on hand for each shift of personnel. Client B's 11/2014 ledger indicated an undated entry after 12/5/14 entry "missing \$31.00 will be refunded by Bona Vista." Client B's 12/10/14 "Purchase Requisition" indicated "\$31.00 this is a reimbursement receipt for money that was stolen from the consumer."</p> <p>-Client G's 12/2014, 11/2014, and 10/2014 ledgers did not indicate two facility staff reviewed and counted client G's cash on hand for each shift of personnel. Client G's 11/2014 ledger indicated an undated entry after 12/5/14 entry "missing \$30.00 will be refunded by Bona Vista." Client G's 12/10/14 "Purchase Requisition" indicated "\$30.00 this is a reimbursement receipt for money that was stolen from the consumer."</p> <p>On 12/18/14 at 10:10am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional), the Group Home Manager (GHM), and the VPRS (Vice President of Residential Services). The GHM stated client A, B, and G's personal funds were "believed to be stolen" from their money pouches at the group home. The GHM and the VPRS both indicated based on the investigation so far the one staff who was</p>		<p>individual plans. A record of trainingform will be completed by all staff members when trainings are finalized.</p> <p>7) Toensure proper monitoring and compliance, the Residential House Manager and QIDPwill make frequent unannounced stops to the group home during various shifts.If staff have failed to implement individual plans as directed, the respectivestaff will be retrained on individual plans and if warranted receiveappropriate disciplinary action as outlined in the agency personnel policiesand procedures.</p>				

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	<p>being shown by a second staff the procedure for counting each client's money every shift were in the office together. The two staff counted out five of eight (5 of 8) client money pouches and reconciled the counted money to each client's ledger (the main ledger and the consumer ledger). The GHM indicated the second staff had excused herself for another matter at the group home and left the one remaining staff in the office alone with the three (3) remaining clients money pouches to count (clients A, B, and G). The staff finished their shifts of work. The GHM indicated the policy and procedure was for two staff to count and reconcile the funds each shift of personnel. The GHM indicated no one counted the clients money again after 12/6/14 until 12/8/14. The GHM stated "the key for the money box was missing also." The GHM stated the staff person who counted client A, B, and G's money on 12/6/14 was a "no show" for work and had not returned to work since the incident. The GHM indicated she obtained a new money box to replace the old box since the key was missing. The GHM indicated the clients money was counted on 12/11/14. The GHM stated the policy and procedure "was always to have two (2) staff count the money each" shift of personnel. The GHM indicated the staff did not follow</p>			
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	<p>the policy and procedure. The GHM indicated the staff were not retrained until 12/17/14 for following the policy and procedure. The GHM indicated no one reported the money box as missing until Monday 12/8/14 when the box was last seen on 12/6/14.</p> <p>On 12/18/14 at 1:00pm, a review of the 10/2011 "Money and Receipt Procedure" indicated "...No more than \$20.00 per consumer will be kept in the cash box at any given time...Staff will count the money that is in the cash box at each shift change. The amount in the cash box will be documented on the main ledger. Another staff on duty will count the money in the cash box to verify and document as witness...Two staff will again document that money and receipts have been returned...Any discrepancies, other than addition/subtraction errors will be reported immediately to the house manager and then the Vice President of Residential Services...."</p> <p>On 12/24/14 at 10:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Vice President of Residential Services (VPRS) was conducted. The QIDP and the VPRS both indicated the facility staff neglected to immediately report that client A, B, and G's money was missing. The VPRS</p>						

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	<p>indicated the facility followed the BDDS reporting policy and procedure for immediately reporting allegations of financial exploitation which included missing money. The VPRS indicated the facility neglected to ensure clients A, B, and G were not victims of financial exploitation.</p> <p>2. On 12/16/14 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and included the following for client H's allegation of a sexual assault at the facility owned workshop:</p> <p>-A 12/2/14 BDDS report for an incident on 12/1/14 at 2:00pm indicated client H had "came home from the workshop around 3:30pm on 12/1/14 and was upset." The report indicated client H told the facility nurse after the nurse continued to ask him why he was upset that "when he went to the bathroom at the workshop today that another consumer followed him into the bathroom. [Client H] stated that [name of consumer] tried to put his penis in my [anus]. [Client H] stated he told him to stop and he did. When [client H] was asked if it hurt he said no." The report indicated the nurse immediately called the Vice President of Residential Services (VPRS) to report the allegation. Client H was assessed by the</p>			

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	<p>nurse and then taken to the hospital emergency room "there were not tears or bruising present. Sexual assault advocate spoke with [client H], a police report was filed...." The report indicated an investigation was initiated by Bona Vista. The report indicated a third client saw the other client following client H into the bathroom. The third client saw client H in client H's bathroom stall with his pants down while using the restroom, the client perpetrator entered client H's bathroom stall pulled his pants down, and the third client stated the client perpetrator "put his penis in [client H's] [anus]." The third client stated "[client H] told [name of perpetrator] to stop once and he did." The perpetrator's witness statement indicated he "pointed" to client H when asked who he followed into the bathroom on 12/1/14. When asked what happened next, the perpetrator stated he "put his [penis] in [client H's] [anus]. When asked what happened then and [the client perpetrator] stated that [client H] did not like it and then they went back to work." The report indicated the staff "that supervises [the perpetrator and client H] was suspended from work pending an investigation...[The perpetrator] has a past history of being the victim of sexual abuse...."</p> <p>-A 12/9/14 Follow up BDDS report to the</p>			

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	<p>incident on 12/1/14 indicated "Based on the investigation, it was determined that the supervisor at the time of the incident was negligent in the responsibilities and care of her consumers. Staff was terminated due to negligent."</p> <p>On 12/24/14 at 10:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Vice President of Residential Services (VPRS) was conducted. The QIDP and the VPRS both indicated the facility staff neglected to ensure the workshop client with a known sexual misconduct history was supervised at the workshop when the workshop client was able to sexually assault client H in the workshop bathroom.</p> <p>3. On 12/16/14 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and indicated the following for client B's AWOL (Absence without Leave) behavior.</p> <p>-A 9/11/14 BDDS report for an incident on 9/10/14 at 6:05pm, indicated "Around 6:08pm, a neighbor notified staff that [client B] was walking down the road. Staff were unaware that [client B] had left the home. They immediately began to look for him." At 6:45pm, client B</p>			

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	<p>was located "about a mile away from the home, sitting on the corner of 400 West and State Road 22." The report indicated client B was not injured "but wet from the rain." The report indicated client B was "upset over some food items." The report indicated client B "had an elopement plan in place and the home has window and door alarms. These alarms will be checked to ensure that they are in proper working conditions."</p> <p>-The 9/11/14 Investigation for client B's 9/10/14 incident indicated client B eloped from the group home "without staffs (sic) knowledge" after becoming "upset at staff when he was asked to clean up his dishes from dinner so he went to his room and stayed there for some time." The investigation indicated "the allegations of neglect are unsubstantiated. Consumer [client B] has a history of elopement on a regular basis." The investigation indicated two (2) staff were on duty with eight (8) clients in the group home.</p> <p>-GHS (Group Home Staff) #8's 9/11/14 witness statement indicated two staff were at the group home during client B's 9/10/14 elopement incident. GHS #8 stated "I think we kinda (sic) realized at the same time. I went into [client B's] bedroom...I realized [client B] wasn't in</p>			

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	<p>his bed. [GHS #7] came in and said some guy came and told her one of our consumers was walking down the road. By the time I got to tell [client H] that I needed to check on someone, [GHS #7] was coming in saying some guy was telling [client H]." GHS #8 stated it was "about 6:10 (no am or pm was indicated)" and GHS #7 was pulling out of the driveway in the van to go look for client B. GHS #8 indicated she called the police to report client B missing after the Group Home Manager called to tell her to call the police.</p> <p>Client B's record was reviewed on 12/18/14 at 2:10pm. Client B's 5/1/14 ISP (Individual Support Plan) and 5/2014 BSP (Behavior Support Plan) both indicated client B had targeted behaviors of Elopement. Client B's plans indicated staff were to provide twenty-four hour supervision. Client B's diagnoses included, but were not limited to: Major Depression, Seizure Disorder, Cerebral Palsy, and Pain Disorder. Client B's 5/1/14 "Elopement Plan" indicated when client B elopes "it is because he upset...staff will be aware of this and keep [client B] within line of sight at all times...[client B] requires 24 hour awake staff, and must remain within line of sight any time that he is in the community...." Client B's Elopement</p>			

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	<p>Plan indicated he was at risk for falls, seizures, and for his safety. Client B's 5/1/14 "Capacity for Independence/Informed Consent" assessment indicated client B does not recognize danger when upset and required supervision in the community, client B was not independent with money or medications, and did not have independent pedestrian safety skills. Client B's assessment indicated the agency staff assist client B to make decisions of informed consent.</p> <p>On 12/24/14 at 10:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Vice President of Residential Services (VPRS) was conducted. The QIDP and the VPRS both indicated the investigation did not substantiate neglect of client B. The QIDP indicated client B was not independent in the community and needed staff to supervise him while in the community. The QIDP indicated client B's Elopement plan indicated staff were to have kept client B within line of sight when he becomes upset to prevent client B's AWOL/Elopement behavior and staff did not implement client B's plans on 9/10/14. The VPRS indicated the facility followed the BDDS policy and procedure for allegations of abuse, neglect, and/or mistreatment. The VPRS indicated</p>						

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	<p>neglect was the failure to provide sufficient staff supervision based on identified behaviors.</p> <p>4. On 12/16/14 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and indicated the following for client F's substantiated staff abuse.</p> <p>-A 7/1/2014 BDDS report for an incident on 7/1/14 at 6:00am, indicated client F was "making himself coffee in the morning when [Group Home Staff (GHS) #9] who was in the kitchen helping with breakfast yelled at [client F] about the creamer and how much he was putting in his coffee cup and the amount of sugar that he was using (sic)." The report indicated [GHS #9] was seen by another staff grabbing the creamer out of [client F's] hands and taking it to the staff office." The report included an investigation into the incident which indicated "After further investigation and interviewing both staff members and consumers, the writer feels that the allegations of verbal abuse are substantiated in that the staff member did in fact raise her voice and yelled at consumer [client F], but it is felt that it may have been in an unintentional manner...It is recommended that the staff member be retrained...on effective</p>			

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	<p>communication when interacting with consumers...." No corrective measures were available for review.</p> <p>On 12/24/14 at 10:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Vice President of Residential Services (VPRS) was conducted. The VPRS indicated the facility followed the BDDS reporting policy and procedure for allegations of staff abuse, neglect, and/or mistreatment. The QIDP indicated client F's allegation was substantiated staff to client inappropriate interaction. The QIDP indicated no corrective action was available for review to ensure GHS #9 was retrained on her interactions with clients and no monitoring was available for review to ensure corrective measures were successfully employed.</p> <p>5. On 12/16/14 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and indicated the following for the facility staff neglecting to supervise clients C and F:</p> <p>-A 10/8/14 BDDS report for an incident on 10/8/14 at 11:00am, indicated clients C and F were "taken to the emergency room for assessment" after staff "had found 4 (four) aerosol cans in [client C</p>			

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	<p>and F's] room and I can had the top off of it...There was a concern that [client F] had inhaled/huffed these aerosol containers...."</p> <p>-A 1/9/14 BDDS report for an incident on 1/9/14 at 2:00am, indicated client F was admitted to the behavioral hospital "following an incident of attempted self harm. He had a belt around his neck and pulled it tight, staff intervned within a minute, removed the belt from his neck. He had a slight mark resulting from it such as a pressure mark (sic)."</p> <p>Client C's record was reviewed on 12/18/14 at 1:40pm. Client C's 9/26/13 ISP (Individual Support Plan) and 9/2014 BSP (Behavior Support Plan) indicated client C required twenty-four hour staff supervision. Client C's diagnoses included, but were not limited to: Schizophrenia, Intermittent Explosive Disorder, Oppositional Defiant Disorder, ADHD (Attention Deficient Hyperactivity Disorder), and Severe Communication Disorder with Apraxia. Client C's plans indicated he had a legal guardian and could not give informed consent.</p> <p>Client F's record was reviewed on 12/18/14 at 12:10pm. Client F's 7/2014 ISP (Individual Support Plan) and 7/2014</p>			

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	<p>BSP (Behavior Support Plan) and 10/2014 revised BSP indicated staff were to supervise client F "one on one" (One staff assigned to supervise client F) by the facility staff. Client F's plans indicated targeted behaviors of Physical Aggression, Verbal Aggression, Property Destruction, Sexual Inappropriate, Resisting Supervision, Suicidal Ideation, and Elopement.</p> <p>On 12/24/14 at 10:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Vice President of Residential Services (VPRS) was conducted. The VPRS indicated the agency followed the BDDS reporting policy and procedure. The QIDP and the VPRS both indicated the facility staff neglected to supervise clients C and F according to their plans and identified needs.</p> <p>On 12/16/14 at 1:00pm, a review was completed of the 10/2005 "Bureau of Developmental Disability Services Policy and Guidelines." The BDDS policy and procedure indicated "...Abuse, Neglect, and Mistreatment of Individuals...it is the policy of the company to ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse by anyone including but not limited to: facility staff...other individuals, or</p>						

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	<p>themselves." The policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual." The policy and procedure indicated "...Neglect, includes failure to provide appropriate care, food, medical care, or supervision...."</p> <p>On 12/16/14 at 1:00pm, a record review of the facility's undated policy and procedures for Abuse, Neglect, Exploitation indicated "Abuse, Neglect, Exploitation" neglect was defined as "failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide the support necessary to an individual's psychological and social well being. Failure to meet the basic need requirements such as food, shelter, clothing and to provide a safe environment...." The policy indicated failure to implement clients' program plans could also be considered neglect. The policy indicated the facility staff should immediately report allegations of abuse, neglect, and/or mistreatment to the administrator and to BDDS in accordance with State Law.</p>			

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W000153	<p>This federal tag relates to complaint #IN00160782.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview, for 2 of 32 BDDS (Bureau of Developmental Disabilities Services) reports reviewed which included 1 allegation for clients A, B, and G's financial exploitation and for 1 report of 3 incidents of client D's repeated falls with injuries, the facility failed to immediately report to the administrator and to BDDS in accordance with State Law for allegations of financial exploitation by the facility staff and for client D's repeated falls with injuries.</p> <p>Findings include:</p> <p>1. On 12/16/14 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and included the following late reporting incidents of financial exploitation for clients A, B, and G:</p>	W000153	<p>Toensure that established agency policies and procedures for incident reportings being implemented and executed as written, the following corrective action(s)will be implemented:</p> <p>1) Allstaff located at 3770 North 80 West (Sycamore group home) will be re-trained onthe agency Personnel Policies and Procedures, Policy III:13: IncidentReporting. Completed Record of Trainings will be obtained and submitted uponcompletion of training. <i>Refer to Appendix B for Record of Trainingform to be used.</i></p>	01/23/2015			

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	<p>-A 12/8/14 BDDS report for an incident on 12/8/14 at 8:00am for clients A, B, and G, indicated the Group Home Staff (GHS) reported to the Residential Home Manager that client A had \$50.00, client B had \$31.00, client G had \$30.00 "missing out of [clients A, B, and G's names] money pouch(es)" and an investigation was initiated.</p> <p>On 12/18/14 at 10:10am, a record review of clients A, B, and G's 10/2014, 11/2014, and 12/2014 "Consumer Ledger(s)" and clients A, B, C, D, E, F, G, and H's 10/2014, 11/2014, and 12/2014 "Main Ledger(s)" were conducted and indicated the following:</p> <p>-The 12/2014 "Main Ledger(s)" were reviewed and indicated one facility staff reviewed and reconciled clients A, B, C, D, E, F, G, and H's cash on hand to the ledger on 12/17/14, 12/16/14, 12/12/14, 12/11/14, 12/6/14, and 12/5/14. The 12/5/14 and 12/6/14 "Main Ledger" indicated the following cash balances for: client A was \$55.00, client B was \$31.61, and client G was \$33.00. The 12/11/14 "Main Ledger" indicated a beginning cash balance for client A zero, client B zero, and client G was zero.</p> <p>-Client A's 12/2014, 11/2014, and</p>			

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	<p>10/2014 ledgers did not indicate two facility staff reviewed and counted client A's cash on hand for each shift of personnel. Client A's 11/2014 ledger indicated an undated entry after 12/5/14 entry "missing \$55.00 will be refunded by Bona Vista." Client A's 12/10/14 "Purchase Requisition" indicated "\$55.00 this is a reimbursement receipt for money that was stolen from the consumer."</p> <p>-Client B's 12/2014, 11/2014, and 10/2014 ledgers did not indicate two facility staff reviewed and counted client B's cash on hand for each shift of personnel. Client B's 11/2014 ledger indicated an undated entry after 12/5/14 entry "missing \$31.00 will be refunded by Bona Vista." Client B's 12/10/14 "Purchase Requisition" indicated "\$31.00 this is a reimbursement receipt for money that was stolen from the consumer."</p> <p>-Client G's 12/2014, 11/2014, and 10/2014 ledgers did not indicate two facility staff reviewed and counted client G's cash on hand for each shift of personnel. Client G's 11/2014 ledger indicated an undated entry after 12/5/14 entry "missing \$30.00 will be refunded by Bona Vista." Client G's 12/10/14 "Purchase Requisition" indicated "\$30.00 this is a reimbursement receipt for money that was stolen from the consumer."</p>						

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	<p>On 12/18/14 at 10:10am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional), the Group Home Manager (GHM), and the VPRS (Vice President of Residential Services). The GHM stated client A, B, and G's personal funds were "believed to be stolen" from their money pouches at the group home. The GHM and the VPRS both indicated based on the investigation so far the one staff who was being shown by a second staff the procedure for counting each client's money every shift were in the office together. The two staff counted out five of eight (5 of 8) client money pouches and reconciled the counted money to each client's ledger (the main ledger and the consumer ledger). The GHM indicated the second staff had excused herself for another matter at the group home and left the one remaining staff in the office alone with the three (3) remaining clients money pouches to count (clients A, B, and G). The GHM indicated the policy and procedure was for two staff to count and reconcile the funds each shift of personnel. The GHM indicated no one counted the clients money again after 12/6/14 until 12/8/14. The GHM stated "the key for the money box was missing also." The GHM stated the staff person who counted client A, B,</p>			
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	<p>and G's money on 12/6/14 was a "no show" for work and had not returned to work since the incident. The GHM indicated the staff did not follow the policy and procedure. The GHM indicated no one reported the money box key or the money as missing until Monday 12/8/14 when the box was last counted on 12/6/14.</p> <p>On 12/18/14 at 1:00pm, a review of the 10/2011 "Money and Receipt Procedure" indicated "...Two staff will again document that money and receipts have been returned...Any discrepancies, other than addition/subtraction errors will be reported immediately to the house manager and then the Vice President of Residential Services...."</p> <p>On 12/24/14 at 10:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Vice President of Residential Services (VPRS) was conducted. The QIDP and the VPRS both indicated the facility staff failed to immediately report that client A, B, and G's money was missing. The VPRS indicated the facility followed the BDDS reporting policy and procedure for immediately reporting allegations of financial exploitation which included missing money.</p>				

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	<p>2. On 12/16/14 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and included late reporting for the following repeated falls for client D:</p> <p>-A 11/21/14 BDDS report for an incident on 11/20/14 at 6:30pm, indicated client D "had fallen on 11/12/14 while at the workshop." The report indicated "there was an accident injury report done due to the fall but there were not injuries that occurred at this time. [Client D] was taken to a walk in clinic for an X-ray of his right elbow due to falling on his right side on 11/12/14. There were no findings on the X-ray. There was a bruise that appeared later as a result of this fall on 11/12/14 that measured 7.9 inches long and 3.5 inches wide. [Client D] was taken on 11/18/14 to the eye doctor to get a check up and everything was fine with this appointment. [Client D] has a neurologist appt. (appointment) on 12/11/14 for an evaluation. He could not get into his GP (General Practitioner) until end of December (2014). On 11/20/14 [Client D] had complaints of left side weakness, left arm numbness, and his head not feeling right. Residential nurse immediately call (sic) [client D's] GP left a message of the change in condition and took [client D] to the walk in clinic. [Client D's] GP</p>			

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	<p>ordered a CT scan (a scan of the head)" and sent client D to the hospital for evaluation and the scan. Client D's lab work and scan "checked out fine." The report indicated client D had "no medical reason for falling. [Client D] has a prior diagnosis of Traumatic Brain Injury from a car wreck over 20 years ago."</p> <p>-A 11/25/14 Follow up BDDS report for the incident on 11/20/14 indicated client D's 7.9 inch by 3.5 inch bruise was "on his right forearm/elbow area and a bruise on his left eye."</p> <p>-A 12/3/14 Follow up BDDS report indicated client D went for an MRI (Magnetic Resonance Imaging) scan of his body organs at the hospital.</p> <p>On 12/16/14 at 1:25pm, a 11/21/14 Investigation into client D's 11/20/14 incident indicated "Investigation of Significant Injury...Due to falls that allegedly occurred at the workshop [client D] had a bruise on his right elbow that measured 7.9 inches long and 3.5 inches wide. [Client D] then started to complain that the left side of his body was numb and there was something wrong with his head." The following were included in the investigative documents:</p>						

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	<p>-A 11/20/14 "Physician's Statement" of visit for "Unsteady gait, dizziness, numbness left leg/arm. Go to [name of hospital] Radiology for STAT (immediate) CT Scan."</p> <p>-A 11/20/14 "CT Scan" results indicated "Atrophy of the cerebella hemispheres is noted...The findings are suspicious for communicating hydrocephalus. No evidence of acute intracranial hemorrhage, infarction or mass effect is noted...." Referred to ER (Emergency Room) for further evaluation.</p> <p>-A 11/20/14 "Physician's Statement" of visit for "ER Hydrocephalus" and referral made to see a neurologist.</p> <p>-A 11/18/14 visual services assessment completed by client D's eye doctor for a "vision exam d/t (due to) L (left) eye injury, redness, itching. Subconjunctival hemorrhage. Artificial tears QID (four times a day), cool compresses as needed for comfort."</p> <p>-The "Day Services Nursing Documentation" log from the facility owned workshop indicated the following falls and information from 11/10/14 through 11/12/14. Client D fell on 11/12/14 at 9:46am. Client D fell in hallway at break refused to be looked at</p>			

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	<p>on 11/10/14 at 10:42am. On 11/10/14 at 11:55am, client D requested "as needed" pain medication.</p> <p>-A witness statement from the Group Home Manager on 11/20/14 at 2:24pm, indicated "I first noticed the black eye on Thursday 11/12/14 when he came home from the workshop. I was told [by another staff] [client D] had fallen three times on Wednesday so (the group home staff) picked up [client D] from the workshop and took him to [name of walk in clinic] to be checked out."</p> <p>On 12/16/14 at 1:25pm, the facility's non BDDS reported "Accident Report(s)" were reviewed for client D and included the following:</p> <p>-A 11/12/14 no hour documented "AM" checked, indicated "Workshop staff reported [client D] had fallen at work and [the group home staff] took [client D] to [walk in clinic]." Client D's 11/12/14 Walk In Clinic Doctor visit indicated "11/12/14...Reason for visit: Pt. (Patient) states that he is here today for low back, L (Left) leg and R (Right) elbow pain. Pt. states he fell 3 x (three times) this morning and that is how his R elbow was hurt. R elbow is swollen, painful, and bruised. Pt. reports that his L leg and low back has been hurting him for about 1</p>			

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	<p>week. Pt. rates pain 10/10 (sic). Pt. caregiver confirms Pt.s account of events and also states she wonders if his new med (medications) Klonopin (for behaviors) is causing him dizziness or if it is from his leg/back as he is not walking normal." The Doctor's report indicated "X-ray OK (Okay)."</p> <p>-A 11/12/14 at 11:35am, indicated client D was "walking to lunch and began to stumble trying to keep his balance after 2 times of an effort not to fall, he did. Falling to his right side to back side. He said his back hurt a little" and client D was assessed by a nurse at the workshop.</p> <p>-A 11/12/14 at 9:45am, indicated client D "fell hard on the way to break. His ambulation has been worse lately. Seems to be dragging his foot as he walks. Had good ROM (Range of Motion) of elbow. Said knee was ok, he fell on it all the time (sic). He was able to get up from floor on his own. Had on the padding of his winter coat at time of fall."</p> <p>-A 11/10/14 at 10:42am, indicated client D fell in the hallway at workshop walking to break. Client D's "peers stated he fell and 3 nurses found [client D] on his knees." The report indicated client D "refused when nursing tried to look at his knees he said he was okay."</p>			

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	<p>Client D's record was reviewed on 10/21/14. Client D's 12/10/14 "Hydrocephalus Plan" indicated Hydrocephalus is an atrophy of fluid around the brain. "Hydrocephalus is the abnormal accumulation of cerebrospinal fluid, usually under increased pressure in the skull, in ventricles of the brain. Symptoms of Hydrocephalus can include: short term memory loss, motion and visual difficulties, shuffling of the feet, difficulty walking, coordination difficulties, slower than normal movements, and poor balance." Client D's 12/3/14 "Falling Management Plan" indicated client D had a "current history of falling" and a "traumatic brain injury" 20 years ago from a car accident. Client D's fall plan indicated staff were to "report immediately All Falls...regardless of the severity of the injury." Client D's Hydrocephalus Plan and Fall Plan both indicated staff were to help client D identify situations and hazards that can cause accidents to increase client D's awareness of potential for falls and staff were to assist client D while walking if unsteady and be "aware" when client D was walking.</p> <p>On 12/24/14 at 10:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Vice</p>			
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W000159	<p>President of Residential Services (VPRS) was conducted. The QIDP and the VPRS both indicated the facility staff immediately reported client D's falls to the administrator and the falls were not reported to BDDS until 11/21/14. The VPRS indicated after a review of client D's repeated falls from 11/10/14 through 11/12/14 an investigation was conducted on 11/21/14. The QIDP indicated client D had no noted injuries and the staff filled out an accident reports for client D's falls. The VPRS indicated no BDDS report was available for review when client D was taken to the walk in clinic on 11/12/14 after his falls and injuries. The VPRS indicated the facility should have followed the BDDS reporting policy and procedure for immediately reporting to BDDS for client D's pattern of falls, injuries, and physician visits as the result of falls.</p> <p>This federal tag relates to complaint #IN00159938.</p> <p>This federal tag relates to complaint #IN00160782.</p> <p>9-3-1(b)(5) 9-3-2(a)</p> <p>483.430(a)</p>				

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	<p>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 1 additional client (client F), the Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate, and monitor client F's active treatment plans to ensure design and delivery which provided client F with appropriate interventions in client F's Individual Support Plan (ISP) and Behavior Support Plan (BSP) to ensure dignity, protection of his client rights, and to ensure the plans effectively addressed client F's needed supports based on his behavioral need.</p> <p>Findings include:</p> <p>On 12/16/14 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and included the following for client F:</p> <p>-A 10/31/14 BDDS report for an incident on 10/30/14 at 3pm, indicated clients A and F were on the van traveling to the bank. Client F began to choke client A's neck, staff intervened, and client A was released.</p>	W000159	<p>To ensure that established agency policies and procedures for incident reporting is being implemented and executed as written, the following corrective action(s) will be implemented:</p> <p>1) The QIDP will revise individual plans for Client F to ensure appropriate interventions and that all needs are effectively met to best benefit him. All staff located at 3370 North 80 West (Sycamore group home) will be retrained on Client F's revised individual plans. A record of training form will be completed by all staff members when trainings are finalized.</p> <p>a. "How will the QIDP be monitored to ensure compliance?"</p> <p>All QIDP's will office during day programming hours out of same facility as the Director and Vice President of Residential Services to ensure adequate support for program implementation. All BSPs, including revisions and additions, will be reviewed by the Director of Residential Services prior to</p>	02/01/2015			

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	<p>-A 10/8/14 BDDS report for an incident on 10/8/14 at 11:00am, indicated clients C and F were "taken to the emergency room for assessment" after staff "had found 4 (four) aerosol cans in [client C and F's] room and 1 can had the top off of it...There was a concern that [client F] had inhaled/huffed these aerosol containers...." Clients C and F were placed on 15 minute staff checks while in their bedroom and checks to be completed by the staff before leaving and upon returning from the group home each day.</p> <p>-A 10/6/14 BDDS report for an incident on 10/6/14 at 10:30am, indicated client F was "upset about missing break at workshop because he had come in late with his home staff after an appointment." The report indicated client F threw his lunch on the ground and refused to walk to his work area. The report indicated the QIDP walked client F to his work area, the QIDP refused to allow client F to smoke, client F threw his cigarettes, and stated "I'm out of here." The QIDP followed behind client F as he "stood up and headed for the door." Client F walked out of the workshop with the QIDP and other staff following him down the city street in the rain, refused to allow staff to hold his gait belt, client F fell "2 times" in the street,</p>		<p>implementation and staff training. Additionally, clientfile audits are being conducted within each home on a monthly basis to ensure timely completion of required paperwork. The Director and Vice President of Residential Services will review a report of each audit on a monthly basis. In the event that deficiencies or unacceptable practices are discovered, the Director and Vice President of Residential Services will require the QIDP to be counseled and re-trained on agency and departmental policies and procedures as well as revise individual client plans to ensure compliance with all state and federal regulations. All trainings will be documented on agency Record of Training forms and retained by the Residential Services Coordinator.</p>	

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	<p>and client F "threatened that when he got to [name of street] he was going to run out into traffic." Staff stayed within an "arm's reach" and got client F into the facility van.</p> <p>-A 7/26/14 BDDS report for an incident on 7/25/14 at 5:00pm, indicated both clients B and F "were transported home from the workshop at 3:30pm" and were outside the group home smoking with staff supervision. Client F "became irritated without provocation, punched [client B] in the face," staff separated the two, and contacted the QIDP (Qualified Intellectual Disabilities Professional). The report indicated client F's BSP (Behavior Support Plan) "has a police protocol that states when physical aggression occurs, the police are to be called to the house. QIDP instructed staff to follow the protocol, and that the RN (Residential Nurse) would be notified, and both would be on their way to the house." The report indicated client B wanted to "press charges against" client F. The police "spoke to the QIDP...and informed the QIDP that he was willing to take [client F] to jail if there were witnesses to the assault...QIDP spoke to the Vice President of Residential Services (VPRS) for Bona Vista and was advised to tell the officer not to take [client F] to jail."</p>				

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	<p>-A 8/4/14 Follow up BDDS report to the 7/25/14 incident indicated "The summons has been filed but the papers haven't been served at this point, so no court date... [client F's] public defender was in process of talking to the prosecutor for a pretrial diversion...." No further information was available for review.</p> <p>-A 7/1/2014 BDDS report for an incident on 7/1/14 at 6:00am, indicated client F was "making himself coffee in the morning when [Group Home Staff (GHS) #9] who was in the kitchen helping with breakfast yelled at [client F] about the creamer and how much he was putting in his coffee cup and the amount of sugar that he was using (sic)." The report indicated [GHS #9] was seen by another staff grabbing the creamer out of [client F's] hands and taking it to the staff office." The report included an investigation into the incident which indicated "After further investigation and interviewing both staff members and consumers, the writer feels that the allegations of verbal abuse are substantiated in that the staff member did in fact raise her voice and yelled at consumer [client F], but it is felt that it may have been in an unintentional manner...It is recommended that the staff member be retrained...on effective</p>			

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	<p>communication when interacting with consumers...."</p> <p>-A 1/9/14 BDDS report for an incident on 1/9/14 at 2:00am, indicated client F was admitted to the behavioral hospital "following an incident of attempted self harm. He had a belt around his neck and pulled it tight, staff intervened within a minute, removed the belt from his neck. He had a slight mark resulting from it such as a pressure mark (sic)."</p> <p>Client F's record was reviewed on 12/18/14 at 12:10pm. Client F's 7/2014 ISP (Individual Support Plan) and 7/2014 BSP (Behavior Support Plan) and 10/2014 revised BSP indicated staff were to use "CPI (Crisis Prevention Intervention) approved techniques." Client F's BSPs indicated "...For all incidents of physical aggression or property destruction direct support professionals will contact on call immediately to report the incident and receive guidance. At any time [client F] cannot be redirected to discontinue his physical aggression or property destruction, If HRC (Human Rights Committee) person approved CPI used as a last resort intervention is not successful, and someone is endangered without being able to be assisted by direct support professionals then 9-1-1 will be called</p>			

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	<p>immediately...Intervention: Use the least restrictive forms of intervention to the most intrusive forms when intervening with any behavior...If [client F] is physically harming anyone else or himself and redirection has not stopped the incident, CPI non violent crisis intervention physical restraint is employed using the least restrictive intervention needed for the situation...."</p> <p>No definition of what CPI techniques were approved was included in the plan. Client F's BSPs did not specifically define which CPI physical restraints were to be used when client F would require a CPI restraint, and failed to indicate a defined hierarchy from least restrictive to most intrusive techniques employed. Client F's BSPs indicated he was to have been supervised "one on one" by the facility staff.</p> <p>Client F's record included a 10/2014 "Background" which indicated client F was admitted on 6/8/2011 from the Marion County Jail. The background indicated "...historical diagnosis of Psychotic Disorder, ADHD (Attention Deficit Hyperactivity Disorder), Oppositional Defiant Disorder...emotional and behavioral difficulties...." Client F had "Started fires" in the past, "...on 4/11/2010 [client F] was arrested with charges of battery,</p>			
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	<p>resisting law enforcement, and criminal confinement. [Client F] was taken to Marion County jail where he remained until 5/28/2010. At that time he was placed [at a] boarding home. [Client F] continued to demonstrate problems with aggression. It is reported that there were a few incidents of aggression that involved throwing/knocking over a television and on the third incident he hit/threw something at someone, which resulted in an arrest with battery charges. He was arrested again and placed at the Marion County jail on 9/28/2010" and client F was kept in "the infirmary of the jail" until he was released to be admitted to the group home on 6/8/2011. Client F "has 2 charges of battery against 2 separate individuals and behavior reports have to be given to his lawyer every 3 months."</p> <p>Client F's record included a 7/2014 BSP which did not document his past history of behaviors, skills, legal issues, or his prior placements.</p> <p>Client F's record included a 10/2014 BSP which indicated "...based on [client F's] statements and actions that he is not remorseful for his actions, such as physical and verbal aggression. Counseling has revealed that [client F] is aware of consequences of his actions and</p>			

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	<p>he does not intend to change his ways, his only remorse comes from consequences such as the legal ramifications he has faced in the past, and is currently facing. [Dr. name] has requested that [client F] have police intervention for his physical aggression, and as a result is now facing charges of assault resulting in bodily injury, and has a court (appearance) scheduled for 9/17/14. [Client F] has a history of suicidal ideation's (sic) and it is believed that these are primarily for attention, and while taken seriously and will be evaluated, [Dr. name] has stated that inpatient psychiatric treatment is not appropriate for [client F]...Threat of Self Injury: [client F] has had times where he had made threats of self injury such as stating that he wants to hang himself...Staff will document any threats that [client F] makes, and monitor him in a discrete manner to ensure his safety...." Client F "is academically between a first and second grade level...requires assistance from direct support professionals at all times and in all situations to ensure his health and safety...requires assistance and redirection from staff...requires complete assistance in all aspects of his financial management, medication, community safety skills, pedestrian skills, and household management...does not possess problem solving skills, and he</p>			

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	<p>tends to react emotionally and aggressively when faced with adversity or feeling frustrated...does not appear to have the ability to be aware of his actions but appears to have limited ability or remorse from his actions. He does not maintain behaviors within reason, as evident with his long history of physical aggression and law enforcement."</p> <p>Client F's 8/4/14 "Therapy Progress Note" documented by the Counselor indicated "...Focus of session: anger management...Session Summary: Per request from [Dr. name] and [QIDP name] that upon consultation stated that if Bona Vista does not allow the police to arrest [client F] in the future for physical aggression toward others and/or does not follow [treatment] plan of contacting the police regarding physical aggression toward others that this department could no longer treat [client F] due to Bona Vista not acting in the client's best interests and potential liability to this department in that regard."</p> <p>On 12/18/14 at 1:00pm, an 8/21/14 unsigned document "Re: Expectations of Employment" directed to the QIDP indicated "Management received a report of unprofessional conduct towards a client during a routine weekly counseling session for the client. Additionally,</p>			

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	<p>management has received reports of you treating some clients more harsh than others and showing favoritism among clients...You will coordinate IDT (Interdisciplinary Team) meetings to review BSPs for all clients in both homes in which you work. Through these meetings you will facilitate the revision of all BSPs to ensure that each plan incorporates appropriate and clearly defined corrective actions for targeted behaviors as well as clearly establishes and outlines re enforcement (sic) plans to be utilized by staff...."</p> <p>On 12/24/14 at 10:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Vice President of Residential Services (VPRS) was conducted. The VPRS indicated client F's 7/2014 BSP was developed by the former QIDP. The VPRS indicated the QIDP person changed in 10/2014. The QIDP and the VPRS both indicated the former QIDP had client F's psychiatrist and counselor "convinced" that client F should "go to jail" when he had behaviors. The VPRS stated "this situation" was discussed with the former QIDP "after I reviewed [client F's] plan." The VPRS stated "Bona Vista does not allow our clients to go to jail" as a result of their identified behaviors. The VPRS indicated client F had the same identified</p>			

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	<p>behaviors before he was admitted to the facility. The VPRS stated client F's 7/2014 BSP was not an "effective" active treatment program plan for client F's behaviors. The VPRS stated "it was a threat of jail" for client F by the QIDP. The VPRS stated client F's BSP was changed to delete the "threat of jail" for known behaviors. The VPRS and the QIDP both indicated client F could tell you the consequences and the right answers to questions asked for not having behaviors. The VPRS and QIDP both stated client F does not demonstrate the "appropriate behaviors" to not display physical aggression, property destruction, and/or self harm. The QIDP and the VPRS both indicated client F could not given informed consent for understanding of legal actions. The QIDP and the VPRS both indicated the facility staff had employed CPI physical restraints on client F to manage his aggressive behaviors. The QIDP indicated client F had physical restraints employed by the facility staff. The QIDP indicated there was no documented evidence which described written interventions from least restrictive to most intrusive techniques staff were to employ for client F's behaviors.</p> <p>9-3-3(a)</p>			

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W000210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on record review, and interview, for 1 of 1 sampled client (client C) who was a new admission to the facility, the facility failed to ensure client C's assessments were completed within 30 days after admission for client C.</p> <p>Findings include:</p> <p>Client C's record was reviewed on 12/18/14 at 1:40pm. Client C's record indicated he was admitted on 6/4/14 from a large facility out of town. Client C's record indicated a 6/16/14 History and Physical completed by his physician, a 12/5/14 completed TB (Tuberculosis Testing/Screening), and a 10/20/14 completed hearing assessment.</p> <p>On 12/24/14 at 10:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client C was admitted 6/4/14. The QIDP indicated client C was a new admission to the facility. The QIDP indicated client C had lived in a large facility out of town. The QIDP indicated the facility had not</p>	W000210	<p>Toensure the completion of all necessary and required assessments for newadmissions, the following corrective action(s) will be implemented:</p> <p>1) Uponthe admission of a new client, the QIDP will schedule all required andnecessary assessments within the first thirty (30) days of admission. Documentation verifying the completionof these assessments will be placed in the client records within the grouphome.</p> <p>2) Toensure timely completion and compliance of required assessments, the Directorof Residential Services will monitor the QIDP and oversee the new admissionprocess. Additionally, the QIDP will be required to provide copies of completedassessments to the Director of Residential Services for review. Failure</p>	01/23/2015
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W000249	<p>completed client C's history and physical, TB test, or his hearing assessment within 30 days of admission and should have been.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview, and record review, for 3 of 4 sampled clients (clients B, C, and D) and for 3 additional clients (clients E, F, and G), the facility failed to use formal and informal opportunities to implement clients B, C, D, E, F, and G's ISPs (Individual Support Plans), BSPs (Behavior Support Plans) and risk plans when opportunities existed.</p> <p>Findings include:</p> <p>1. During observations on 12/17/14 from 8:45am until 10:40am at the facility owned workshop, clients C and F were asleep at their work tables and were not prompted or encouraged to participate in</p>	W000249	<p>to complete required assessments within the first thirty (30) days of admission may result in disciplinary action as outlined in the agency personnel policies and procedures.</p> <p>To ensure proper execution of individual plans for clients residing in the group home, the following corrective action(s) will be implemented: 1) The QIDP will revise individual plans for all clients residing in the home to ensure needs are met. All staff located at 3370 North 80 West (Sycamore group home) will be retrained on all revised individual plans. A record of training form will be completed by all staff upon completion of training.</p> <p>a. "The submitted POC does not address the cited deficiency. Please refer to the guidelines for submitting an acceptable POC."</p> <p>The QIDP will revise</p>	02/01/2015	

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	activity by the workshop staff. At 9:15am, Workshop Staff (WKS) #1 stated client G who was not at the workshop yet today "sleeps a lot. [Client G] throws himself on the ground when he stumbles." At 9:15am, WKS #1 indicated client D slept during workshop hours at times. At 9:30am, client F's work area supervisor announced break time and client F continued to sleep at his work table. Client C woke up, got up from his chair, and went on break with the other workshop clients. At 9:30am, client D arrived in the facility van with his group home staff and used a wheel chair to be assisted by the staff from the van into the workshop area. At 9:30am, client D then exited the workshop to go on break and smoke outside with the other clients from the workshop. At 9:55am, client C returned from break, sat down at his workshop table, and went back to sleep. Client C was not prompted or encouraged for activity by the workshop staff. From 9:55am until 10:40am, client D returned from break to his workshop table and sat without activity prompted or encouraged by the workshop staff. At 10:30am, client D sat in a wheelchair at his work table with his eyes closed, and slowly leaned forward and backward in his wheelchair. From 10:05 until 10:40am, client C sat at his work table asleep and was not prompted		individual plansfor all clients residing in the home to ensure needs are met. All staff locatedat 3370 North 80 West (Sycamore group home) will be retrained on all revisedindividual plans. A record of training form will be completed by all staff uponcompletion of training. The Qualified Developmental Disabilities Professional(QDDP) and Residential House Manager (RHM) will alternate working variousshifts in the home alongside direct support staff. If insufficiencies in level of care by staff are noted by the QDDPand/or RHM, the Director and Vice President of Residential Services will beimmediately notified. Upon notification, the Director and Vice President ofResidential Services will require all staff working in the home to be counseledand re-trained on agency and departmental policies and procedures as well asindividual client plans. All trainings will be documented on agency Record ofTraining forms and retained by the				

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	<p>or encouraged for activity by the workshop staff.</p> <p>Client C's record was reviewed on 12/18/14 at 1:40pm. Client C's 9/26/14 ISP (Individual Support Plan) indicated objectives/goals to make correct change from \$5.00, to cook a side dish with requires at least two steps, to identify appropriate uses for knives, to identify safety precautions when using knives, to use appropriate coping skills, to display sexually appropriate behaviors, to identify the reason for taking Depakote (for behaviors), to identify the reason for taking Zyprexa (for behaviors), and to increase my productivity.</p> <p>Client D's record was reviewed on 12/18/14 at 1:00pm. Client D's 10/21/14 ISP indicated objectives/goals to identify the reason for taking Naproxen (for pain and discomfort), to gather all ingredients for a recipe, to purchase an item with programming money, to dress in clothes appropriate for the weather, to not make inappropriate comments to females, to have zero instances of verbal aggression, to have zero incidents of physical aggression, to state his address, and to state his phone number. Client D's ISP did not include a workshop production goal/objective.</p>		Residential Services Coordinator.				

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	<p>Client F's record was reviewed on 12/18/14 at 12:10pm. Client F's 7/14/14 ISP indicated objectives/goals to identify the change received for a purchase less than \$10.00, to increase his self direction, to stay at his workstation 100% of the time, to increase his compliance with workshop policy to refrain from acts of aggression, to complete academic activities of his choosing, to identify the side effects of Zyprexa (for behaviors) medication, to prepare a baked dessert following a recipe, to load/unload the dishwasher appropriately, to carry his ID in his wallet, to identify the consequences to various actions, to have zero incidents of physical aggression, and to use relaxation techniques when becoming upset.</p> <p>On 12/24/14 at 10:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Vice President of Residential Services (VPRS) was conducted. The QIDP indicated clients C, D, and F's ISPs were not implemented when opportunities existed. The QIDP and the VPRS both indicated clients should be offered and encouraged activities at the workshop. The QIDP indicated staff should use formal and informal opportunities to teach and train on skills.</p>			

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	<p>2. On 12/17/14 at 6:48am, Group Home Staff (GHS) #1 asked client B to come to the medication room. GHS #1 selected client B's "Levothyroxine 112mcg (Micrograms) take 1 tablet by mouth daily" for Hypothyroidism, dispensed the tablet into a medication cup, and prompted client B to take the medication. No teaching or training was observed offered or encouraged by GHS #1.</p> <p>Client B's record was reviewed on 12/18/14 at 2:10pm. Client B's 5/1/14 ISP indicated objectives/goals to identify the side effect of Depakote tablet and to identify the side effect of Levothyroxine tablet medications.</p> <p>On 12/17/14 at 6:40am, GHS #1 asked client G to come to the medication room. GHS #1 selected client G's "Levothyroxine 50mcg tablet take 1 tablet by mouth every morning without food" for Hypothyroidism, GHS #1 dispensed the tablet into a medication cup, and prompted client G to take the medication. No teaching or training was observed offered or encouraged by GHS #1.</p> <p>Client G's record was reviewed on 12/18/14 at 11:15am. Client G's 10/17/14 ISP indicated objectives/goals to identify the reason for taking Geodon</p>				

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	<p>tablet for behaviors and to identify the reason for taking his Depakote tablet for behaviors.</p> <p>On 12/17/14 at 7:10am, GHS #1 asked client F to come to the medication room. GHS #1 selected client F's "Carbamazepine ER 200mg (milligrams) tablet, take 1 tablet by mouth every morning" for behaviors (and) Olanzapine 10mg tablet, take 1 tablet by mouth twice a day" for behaviors. GHS #1 dispensed the tablets into a medication cup and prompted client F to take the medication. No teaching or training was observed offered or encouraged by GHS #1.</p> <p>Client F's record was reviewed on 12/18/14 at 12:10pm. Client F's 7/14/14 ISP indicated objectives/goals to identify the side effects of Zyprexa (for behaviors) medication.</p> <p>On 12/24/14 at 10:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Vice President of Residential Services (VPRS) was conducted. The QIDP indicated client B, F, and G's ISP objectives/goals should be implemented by the facility staff during formal and informal opportunities. The QIDP indicated the facility staff should teach the clients the names, reasons, and doses of the</p>						

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	<p>medications each client was administered when informal opportunities existed.</p> <p>3. On 12/16/14 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and included the following repeated falls for client D:</p> <p>-A 11/21/14 BDDS report for an incident on 11/20/14 at 6:30pm, indicated client D "had fallen on 11/12/14 while at the workshop." The report indicated "there was an accident injury report done due to the fall but there were not injuries that occurred at this time. [Client D] was taken to a walk in clinic for an X-ray of his right elbow due to falling on his right side on 11/12/14. There were no findings on the X-ray. There was a bruise that appeared later as a result of this fall on 11/12/14 that measured 7.9 inches long and 3.5 inches wide. [Client D] was taken on 11/18/14 to the eye doctor to get a check up and everything was fine with this appointment. [Client D] has a neurologist appt. (appointment) on 12/11/14 for an evaluation. He could not get into his GP (General Practitioner) until end of December (2014). On 11/20/14 [Client D] had complaints of left side weakness, left arm numbness, and his head not feeling right. Residential nurse immediately call (sic)</p>						

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	<p>[client D's] GP left a message of the change in condition and took [client D] to the walk in clinic. [Client D's] GP ordered a CT scan (a scan of the head)" and sent client D to the hospital for evaluation and the scan. Client D's lab work and scan "checked out fine." The report indicated client D had "no medical reason for falling. [Client D] has a prior diagnosis of Traumatic Brain Injury from a car wreck over 20 years ago."</p> <p>-A 11/25/14 Follow up BDDS report for the incident on 11/20/14 indicated client D's 7.9 inch by 3.5 inch bruise was "on his right forearm/elbow area and a bruise on his left eye."</p> <p>-A 12/3/14 Follow up BDDS report indicated client D went for an MRI (Magnetic Resonance Imaging) scan of his body organs at the hospital.</p> <p>On 12/16/14 at 1:25pm, a 11/21/14 Investigation into client D's 11/20/14 incident indicated "Investigation of Significant Injury...Due to falls that allegedly occurred at the workshop [client D] had a bruise on his right elbow that measured 7.9 inches long and 3.5 inches wide. [Client D] then started to complain that the left side of his body was numb and there was something wrong with his head." The following</p>			

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	<p>were included in the investigative documents:</p> <p>-A 11/20/14 "Physician's Statement" of visit for "Unsteady gait, dizziness, numbness left leg/arm. Go to [name of hospital] Radiology for STAT (immediate) CT Scan."</p> <p>-A 11/20/14 "CT Scan" results indicated "Atrophy of the cerebella hemispheres is noted...The findings are suspicious for communicating hydrocephalus. No evidence of acute intracranial hemorrhage, infarction or mass effect is noted...." Referred to ER (Emergency Room) for further evaluation.</p> <p>-A 11/20/14 "Physician's Statement" of visit for "ER Hydrocephalus" and referral made to see a neurologist.</p> <p>-A 11/18/14 visual services assessment completed by client D's eye doctor for a "vision exam d/t (due to) L (left) eye injury, redness, itching. Subconjunctival hemorrhage. Artificial tears QID (four times a day), cool compresses as needed for comfort."</p> <p>-The "Day Services Nursing Documentation" log from the facility owned workshop indicated the following falls and information from 11/10/14</p>						

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	<p>through 11/12/14. Client D fell on 11/12/14 at 9:46am. Client D fell in hallway at break refused to be looked at on 11/10/14 at 10:42am. On 11/10/14 at 11:55am, client D requested "as needed" pain medication.</p> <p>-A witness statement from the Group Home Manager on 11/20/14 at 2:24pm, indicated "I first noticed the black eye on Thursday 11/12/14 when he came home from the workshop. I was told [by another staff] [client D] had fallen three times on Wednesday so (the group home staff) picked up [client D] from the workshop and took him to [name of walk in clinic] to be checked out."</p> <p>On 12/16/14 at 1:25pm, the facility's non BDDS reported "Accident Report" were reviewed for client D and included the following:</p> <p>-A 11/12/14 no hour documented "AM" checked, indicated "Workshop staff reported [client D] had fallen at work and [the group home staff] took [client D] to [walk in clinic]." Client D's 11/12/14 Walk In Clinic Doctor visit indicated "11/12/14...Reason for visit: Pt. (Patient) states that he is here today for low back, L (Left) leg and R (Right) elbow pain. Pt. states he fell 3 x (three times) this morning and that is how his R elbow was</p>			

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	<p>hurt. R elbow is swollen, painful, and bruised. Pt. reports that his L leg and low back has been hurting him for about 1 week. Pt. rates pain 10/10 (sic). Pt. caregiver confirms Pt.s account of events and also states she wonders if his new med (medications) Klonopin (for behaviors) is causing him dizziness or if it is from his leg/back as he is not walking normal." The Doctor's report indicated "X-ray OK (Okay)."</p> <p>-A 11/12/14 at 11:35am, indicated client D was "walking to lunch and began to stumble trying to keep his balance after 2 times of an effort not to fall, he did. Falling to his right side to back side. He said his back hurt a little" and client D was assessed by a nurse at the workshop.</p> <p>-A 11/12/14 at 9:45am, indicated client D "fell hard on the way to break. His ambulation has been worse lately. Seems to be dragging his foot as he walks. Had good ROM (Range of Motion) of elbow. Said knee was ok, he fell on it all the time (sic). He was able to get up from floor on his own. Had on the padding of his winter coat at time of fall."</p> <p>-A 11/10/14 at 10:42am, indicated client D fell in the hallway at workshop walking to break. Client D's "peers stated he fell and 3 nurses found [client</p>			

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	<p>D] on his knees." The report indicated client D "refused when nursing tried to look at his knees he said he was okay."</p> <p>Client D's record was reviewed on 10/21/14. Client D's 12/10/14 "Hydrocephalus Plan" indicated Hydrocephalus is an atrophy of fluid around the brain. "Hydrocephalus is the abnormal accumulation of cerebrospinal fluid, usually under increased pressure in the skull, in ventricles of the brain. Symptoms of Hydrocephalus can include: short term memory loss, motion and visual difficulties, shuffling of the feet, difficulty walking, coordination difficulties, slower than normal movements, and poor balance." Client D's 12/3/14 "Falling Management Plan" indicated client D had a "current history of falling" and a "traumatic brain injury" 20 years ago from a car accident. Client D's fall plan indicated staff were to "report immediately All Falls...regardless of the severity of the injury." Client D's Hydrocephalus Plan and Fall Plan both indicated staff were to help client D identify situations and hazards that can cause accidents to increase client D's awareness of potential for falls and staff were to assist client D while walking if unsteady and be "aware" when client D was walking. Client D's Hydrocephalus Plan and Fall Management Plan before</p>			

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	<p>his 11/2014 falls were not available for review.</p> <p>On 12/24/14 at 10:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Vice President of Residential Services (VPRS) was conducted. The QIDP indicated client D's plans were updated after his most recent falls. The QIDP and the VPRS both indicated the facility staff failed to implement client D's plans to provide education and encouragement to prevent client D's repeated falls.</p> <p>4. On 12/16/14 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and indicated the following for client B's AWOL (Absence without Leave) behavior and lack of staff supervision.</p> <p>-A 9/11/14 BDDS report for an incident on 9/10/14 at 6:05pm, indicated "Around 6:08pm, a neighbor notified staff that [client B] was walking down the road. Staff were unaware that [client B] had left the home. They immediately began to look for him." At 6:45pm, client B was located "about a mile away from the home, sitting on the corner of 400 West and State Road 22." The report indicated client B was not injured "but wet from</p>						

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	<p>the rain." The report indicated client B was "upset over some food items." The report indicated client B "had an elopement plan in place and the home has window and door alarms. These alarms will be checked to ensure that they are in proper working conditions."</p> <p>-The 9/11/14 Investigation for client B's 9/10/14 incident indicated client B eloped from the group home "without staffs (sic) knowledge" after becoming "upset at staff when he was asked to clean up his dishes from dinner so he went to his room and stayed there for some time." The investigation indicated "the allegations of neglect are unsubstantiated. Consumer [client B] has a history of elopement on a regular basis." The investigation indicated two (2) staff were on duty with eight (8) clients in the group home.</p> <p>-GHS (Group Home Staff) #8's 9/11/14 witness statement indicated two staff were at the group home during client B's 9/10/14 elopement incident. GHS #8 stated "I think we kinda (sic) realized at the same time. I went into [client B's] bedroom...I realized [client B] wasn't in his bed. [GHS #7] came in and said some guy came and told her one of our consumers was walking down the road. By the time I got to tell [client H] that I</p>						

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	<p>needed to check on someone, [GHS #7] was coming in saying some guy was telling [client H]." GHS #8 stated it was "about 6:10 (no am or pm was indicated)" and GHS #7 was pulling out of the driveway in the van to go look for client B. GHS #8 indicated she called the police to report client B missing after the Group Home Manager called to tell her to call the police.</p> <p>Client B's record was reviewed on 12/18/14 at 2:10pm. Client B's 5/1/14 ISP (Individual Support Plan) and 5/2014 BSP (Behavior Support Plan) both indicated client B had targeted behaviors of Elopement. Client B's plans indicated staff were to provide twenty-four hour supervision. Client B's diagnoses included, but were not limited to: Major Depression, Seizure Disorder, Cerebral Palsy, and Pain Disorder. Client B's 5/1/14 "Elopement Plan" indicated when client B elopes "it is because he upset...staff will be aware of this and keep [client B] within line of sight at all times...[client B] requires 24 hour awake staff, and must remain within line of sight any time that he is in the community...." Client B's Elopement Plan indicated he was at risk for falls, seizures, and for his safety. Client B's 5/1/14 "Capacity for Independence/Informed Consent"</p>			

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	<p>assessment indicated client B does not recognize danger when upset and required supervision in the community, client B was not independent with money or medications, and did not have independent pedestrian safety skills.</p> <p>On 12/24/14 at 10:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Vice President of Residential Services (VPRS) was conducted. The QIDP indicated client B was not independent in the community and needed staff to supervise him while in the community. The QIDP indicated client B's Elopement plan indicated staff were to have kept client B within line of sight when he becomes upset to prevent client B's AWOL/Elopement behavior and staff did not implement client B's plans on 9/10/14. The VPRS indicated the facility failed to provide sufficient staff supervision based on identified behaviors.</p> <p>5. On 12/16/14 at 1:25pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and indicated the following for the facility staff failing to supervise clients C and F:</p> <p>-A 10/8/14 BDDS report for an incident</p>				

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	<p>on 10/8/14 at 11:00am, indicated clients C and F were "taken to the emergency room for assessment" after staff "had found 4 (four) aerosol cans in [client C and F's] room and 1 can had the top off of it... There was a concern that [client F] had inhaled/huffed these aerosol containers...."</p> <p>-A 1/9/14 BDDS report for an incident on 1/9/14 at 2:00am, indicated client F was admitted to the behavioral hospital "following an incident of attempted self harm. He had a belt around his neck and pulled it tight, staff intervened within a minute, removed the belt from his neck. He had a slight mark resulting from it such as a pressure mark (sic)."</p> <p>Client C's record was reviewed on 12/18/14 at 1:40pm. Client C's 9/26/13 ISP (Individual Support Plan) and 9/2014 BSP (Behavior Support Plan) indicated client C required twenty-four hour staff supervision. Client C's diagnoses included, but were not limited to: Schizophrenia, Intermittent Explosive Disorder, Oppositional Defiant Disorder, ADHD (Attention Deficit Hyperactivity Disorder), and Severe Communication Disorder with Apraxia. Client C's plans indicated he had a legal guardian and could not give informed consent.</p>						

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W000289	<p>Client F's record was reviewed on 12/18/14 at 12:10pm. Client F's 7/2014 ISP (Individual Support Plan) and 7/2014 BSP (Behavior Support Plan) and 10/2014 revised BSP indicated staff were to supervise client F "one on one" (One staff assigned to supervise client F) by the facility staff. Client F's plans indicated targeted behaviors of Physical Aggression, Verbal Aggression, Property Destruction, Sexual Inappropriate, Resisting Supervision, Suicidal Ideation, and Elopement.</p> <p>On 12/24/14 at 10:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Vice President of Residential Services (VPRS) was conducted. The QIDP and the VPRS both indicated the facility staff failed to supervise clients C and F according to their plans and identified needs.</p> <p>This federal tag relates to complaint #IN00159938.</p> <p>9-3-4(a)</p> <p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual</p>			

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	<p>program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on record review and interview, for 1 of 4 clients (client F) who had restrictive techniques employed, the facility failed to clearly define the specific techniques utilized in client F's Behavior Support Plan (BSP).</p> <p>Findings include:</p> <p>Client F's record was reviewed on 12/18/14 at 12:10pm. Client F's 7/2014 ISP (Individual Support Plan) and 7/2014 BSP (Behavior Support Plan) and 10/2014 revised BSP indicated staff were to use "CPI (Crisis Prevention Intervention) approved techniques." Client F's BSPs indicated "...For all incidents of physical aggression or property destruction direct support professionals will contact on call immediately to report the incident and receive guidance. At any time [client F] cannot be redirected to discontinue his physical aggression or property destruction, If HRC (Human Rights Committee) person approved CPI used as a last resort intervention is not successful, and someone is endangered without being able to be assisted by direct support professionals then 9-1-1 will be called immediately...Intervention: Use the least restrictive forms of intervention to the</p>	W000289	<p>Toensure proper execution of individual plans for Client F, the followingcorrective action(s) will be implemented:</p> <p>1) TheQIDP revised the Behavior Support Plan (BSP) on October 14, 2014, whichincluded an incentive plan in which he can earn up to \$5.00 a week from thehousehold petty cash. HRC approved on October 28, 2014. Following HRC approval,all staff located at 3770 North 80 West (Sycamore group home) were trained onthe revisions to the BSP for client #4. 2) TheQIDP revised the Fall plan for Client #4 on December 5, 2014. Al staff locatedat 3770 North 80 West (Sycamore group home) were trained on the revisions tothe Fall Plan for client #4. 3) OnDecember 1, 2014, Client # 4 began new counseling services to include, but notlimited to Cognitive Behavioral Therapy. Client #4 is responding to thecounseling and behaviors are decreasing.</p> <p>1. "The dates of review are before the survey was conducted. They cannot be used for a plan of correction. Please submit an acceptable plan of correction."</p> <p>1) TheQIDP will revise the Behavior Support Plan (BSP) to include an incentive planin</p>	02/01/2015

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	<p>most intrusive forms when intervening with any behavior...If [client F] is physically harming anyone else or himself and redirection has not stopped the incident, CPI non violent crisis intervention physical restraint is employed using the least restrictive intervention needed for the situation..." No definition of what CPI techniques were approved was included in the plan. Client F's BSPs did not specifically define which CPI physical restraints were to be used when client F would require a CPI restraint, and failed to indicate a defined hierarchy from least restrictive to most intrusive techniques employed.</p> <p>On 12/24/14 at 10:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Vice President of Residential Services (VPRS) was conducted. The QIDP and the VPRS both indicated the facility staff had employed CPI physical restraints on client F to manage his aggressive behaviors. The QIDP indicated client F had physical restraints employed by the facility staff. The QIDP indicated there was no documented evidence which described written interventions from least restrictive to most intrusive techniques staff were to employ for client F's behaviors. The QIDP indicated client F's BSPs did not state and/or define the</p>		<p>which he can earn up to \$5.00 a week from the household petty cash. HRC will be sought for approval of the incentive plan. Following HRC approval, all staff located at 3770 North 80 West (Sycamore group home) will be trained on therevisions to the BSP for client #4. Record of training forms will be completedonce all trainings are finalized.</p> <p>2) TheQIDP will revise the fall plan for Client #4 on. All staff located at 3770North 80 West (Sycamore group home) will be re-trained on the revisions to theFall Plan for client #4. Record of training forms will be completed once alltrainings are finalized.</p> <p>3) Client# 4 will begin new counseling services to include, but not limited toDialectical Behavioral Therapy (DBT). Client #4 is responding to the counselingand behaviors are decreasing.</p>	

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W000436	<p>specific techniques used for client F.</p> <p>9-3-5(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview, for 2 of 3 sampled clients (clients A and B) who wore eye glasses, the facility failed to teach and encourage clients A and B to wear their prescribed eye glasses at the workshop.</p> <p>Findings include:</p> <p>On 12/17/14 from 8:45am until 10:40am, observation was conducted at the workshop and clients A and B did not wear their prescribed eye glasses.</p> <p>During the observation period clients A and B walked throughout the workshop, walked to access the facility breakroom, bent at their waists while seated at a table, leaned over their page to color on a sheet of paper, and their faces were within inches of the sheet of paper. Clients A and B were not encouraged to</p>	W000436	<p>Toensure proper execution of the vision plans for Client A and B, the followingcorrective action(s) will be implemented:</p> <p>1) Allstaff located at the location of 3770 North 80 West (Sycamore group home) willreceive re-training on the vision plans for Clients A and B. Completed Recordof Trainings will be obtained and submitted upon completion of training. 2) Allpertinent workshop staff including designated supervisors and QIDP will receive re-training on the vision plans for Clients A and B. Completed Record Trainingswill be obtained and submitted upon completion of training. 3) TheQIDP will develop informal goals for Clients A and B to assist with teachingand encouraging both clients to wear their glasses both while at home and dayprogramming.</p> <p>a. "Howwill the facility monitor to ensure</p>	02/01/2015

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	<p>wear their prescribed eyeglasses.</p> <p>Client A's record was reviewed on 12/18/14 at 2:45pm. Client A's 4/24/13 visual examination indicated client A wore prescribed eye glasses to see. Client A's 4/2/14 ISP (Individual Support Plan) did not indicate an objective to teach and wear her prescribed eye glasses. Client A's record indicated an objective to complete her reading activities daily.</p> <p>Client B's record was reviewed on 12/18/14 at 2:10pm. Client B's 5/29/13 visual examination indicated client B wore prescribed eye glasses to see. Client B's 9/12/14 ISP (Individual Support Plan) indicated an objective for client B to wear his prescribed eye glasses throughout the day.</p> <p>On 12/24/14 at 10:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Vice President of Residential Services (VPRS) was conducted. The QIDP indicated clients A and B wore prescribed eye glasses to see. The QIDP indicated staff should use formal and informal opportunities to teach and encourage clients A and B to wear their prescribed eye glasses.</p>		<p>compliance?"</p> <p>The Qualified Developmental Disabilities Professional (QDDP) and Residential House Manager (RHM) will alternate working various shifts in the home alongside direct support staff. If insufficiencies in level of care by staff are noted by the QDDP and/or RHM, the Director and Vice President of Residential Services will be immediately notified. Upon notification, the Director and Vice President of Residential Services will require all staff working in the home to be counseled and re-trained on agency and departmental policies and procedures as well as individual client plans. All trainings will be documented on agency Record of Training forms and retained by the Residential Services Coordinator.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	9-3-7(a)				