

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G793	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/19/2014
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 113 S 325 E VALPARAISO, IN 46385
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W000000	<p>This visit was for the investigation of complaint #IN00158518.</p> <p>Complaint #IN00158518: Substantiated, Federal/state deficiencies related to the allegations are cited at W104, W122, W149, W154, W157, W159, W186 and W189.</p> <p>Dates of Survey: November 3, 6, 7, 12, 13, 14 and 19, 2014.</p> <p>Facility number: 012584 Provider number: 15G793 AIM number: 201018520</p> <p>Surveyor: Christine Colon, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/1/14 by Ruth Shackelford, QIDP.</p>	W000000		

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

TITLE

(X6) DATE

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

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W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 2 of 2 sampled clients (clients A and B), the governing body failed to exercise operating direction over the facility to implement its written policies and procedures to prevent abuse/neglect of clients in regard to client to client aggression and client elopement. The governing body failed to conduct a thorough investigation in regard to an incident of client A's elopement which led to his incarceration. The governing body failed to put in place sufficient/effective corrective measures to prevent client A's recurrence of elopement. The governing body failed to provide sufficient staffing while transporting out in the community. The governing body failed to ensure group home staff showed competence in implementing client A's protocols/plans to prevent client A's elopement. The governing body failed to ensure the facility's Inter Disciplinary Team (IDT) met and addressed client A's elopement, incarceration and calling emergency services to the group home when emergencies did not arise.</p> <p>Findings include:</p>	W000104	<p>W 104 483.410(a)(1) GOVERNING BODY In conjunction with the Plans of Correction for W122, W149, W154, W157, W159, W186, and W189. The Area Director, House Manager, and QDDP have reviewed this Standard. (Note: The QDDP was incorrect in stating that Client A's protocol required two staff to be with him while in the community. At the time of the incident, Client A required one-on-one staffing according to his plan/protocol). However, due to the incident, Client A is now required two staff while in the community to prevent elopement and/or incarceration. Client A's IDT met to discuss and implement protocol to prevent recurrence of Client A's client to client abuse, elopement, and calling 911 when not an emergency. All staff have been trained to ensure competency in implementing this protocol. Client A's IDT will monitor the effectiveness of this Protocol and meet as necessary to ensure no recurrence of Client A's elopement, abuse towards other clients, or dialing 911 when not an emergency. The Area Director, House Manager, and QDDP have been retrained on ensuring the facility implements its written</p>	12/13/2014	

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	<p>1. Please refer to W149: The governing body neglected for 2 of 2 sampled clients (clients A and B) residing at the group home, to implement written policy and procedures to prevent to prevent client to client aggression and to prevent client A from elopement.</p> <p>2. Please refer to W154: The governing body failed for 1 of 2 sampled clients (client A), to provide written evidence a thorough investigation was conducted in regard to client A's incident of elopement which led to his incarceration.</p> <p>3. Please refer to W157: The governing body failed for 1 of 2 sampled clients (client A), to take sufficient/effective corrective measures in regard to client A's elopement which led to his incarceration.</p> <p>4. Please refer to W159: The governing body failed for 1 of 2 sampled clients (client A), to ensure the Qualified Intellectual Disabilities Professional (QIDP) coordinated with client A's Inter Disciplinary Team (IDT) to ensure measures were put in place to protect client A from his identified behavioral needs upon returning to the group home after being incarcerated.</p>		<p>policies and procedures to prevent abuse/neglect of any clients in regards to client to client aggression and client elopement; to conduct thorough investigations into any incidents of elopement and client to client aggression; to ensure sufficient/effective corrective measures are put in place to prevent recurrence of elopement and client to client abuse; to ensure staff show competence in implementing all individual plans/protocols to prevent client to client abuse and elopement; to ensure all Individuals' IDT's meet promptly and address incidents of elopement, client to client abuse, and calling emergency services to the group home when not an emergency. The House Manager and/or QDDP will promptly report to the Area Director, per Policy, and the Area Director will monitor and ensure compliance with this Standard. Beginning 11/19/14 and continuing through 12/19/14, then at least every week thereafter if in compliance, QDDP, House Manager, Nurse, and/or Behaviorist have been conducting observations at least 5 times per week to ensure this Standard is being met and that all staff are consistently following the Individuals' plans and following policy/procedures. Will be completed by: 12/13/14 Persons Responsible: Area Director, House Manager, and QDDP</p>				

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W000122	<p>5. Please refer to W186: The governing body failed for 1 of 2 sampled clients (client A) to ensure sufficient staffing was provided to ensure supervision to prevent elopement while out in the community.</p> <p>6. Please refer to W189: The governing body failed for 1 of 2 sampled clients (client A), to ensure all staff who worked with client A were sufficiently trained to assure competence in regard to the client's behavioral needs/plans.</p> <p>This federal tag relates to complaint #IN00158518.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 2 of 2 sampled clients (clients A and B). The facility failed to implement its written policies and procedures to prevent abuse/neglect of clients in regard to client to client aggression and client elopement. The facility failed to conduct a thorough investigation in regard to an</p>	W000122	<p>W 122 483.420 CLIENT PROTECTIONS</p> <p>In conjunction with the Plans of Correction for W104, W149, W154, W157, W159, W186, and W189. The Area Director, House Manager, and QDDP have reviewed this Condition of Participation. (Note:</p>	12/13/2014	

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	<p>incident of client A's elopement which led to his incarceration. The facility failed to put in place sufficient/effective corrective measures to prevent client A's recurrence of elopement. The facility failed to provide sufficient staffing while transporting out in the community. The facility failed to ensure group home staff showed competence in implementing client A's protocols/plans to prevent client A's elopement. The facility failed to ensure the facility's Inter Disciplinary Team (IDT) met and addressed client A's elopement, incarceration and calling emergency services to the group home when emergencies did not arise.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Please refer to W149: The facility neglected for 2 of 2 sampled clients (clients A and B) residing at the group home, to implement written policy and procedures to prevent to prevent client to client aggression and to prevent client A from elopement. 2. Please refer to W154: The facility failed for 1 of 2 sampled clients (client A), to provide written evidence a thorough investigation was conducted in regard to client A's incident of elopement which led to his incarceration. 		<p>The QDDP was incorrect in stating that Client A's protocol required two staff to be with him while in the community. At the time of the incident, Client A required one-on-one staffing according to his plan/protocol). However, due to the incident, Client A is now required two staff while in the community to prevent elopement and/or incarceration. Client A's IDT met to discuss and implement protocol to prevent recurrence of Client A's client to client abuse, elopement, and calling 911 when not an emergency. All staff have been trained to ensure competency in implementing this protocol. Client A's IDT will monitor the effectiveness of this Protocol and meet as necessary to ensure no recurrence of Client A's elopement, abuse towards other clients, or dialing 911 when not an emergency. The Area Director, House Manager, and QDDP have been retrained on ensuring the facility implements its written policies and procedures to prevent abuse/neglect of any clients in regards to client to client aggression and client elopement; to conduct thorough investigations into any incidents of elopement and client to client aggression; to ensure sufficient/effective corrective measures are put in place to prevent recurrence of elopement and client to client abuse; to ensure staff show competence in implementing all individual plans/protocols to prevent client to client abuse and elopement;</p>		

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	<p>3. Please refer to W157: The facility failed for 1 of 2 sampled clients (client A), to take sufficient/effective corrective measures in regard to client A's elopement which led to his incarceration.</p> <p>4. Please refer to W159: The facility failed for 1 of 2 sampled clients (client A), to ensure the Qualified Intellectual Disabilities Professional (QIDP) coordinated with client A's Inter Disciplinary Team (IDT) to ensure measures were put in place to protect client A from his identified behavioral needs upon returning to the group home after being incarcerated.</p> <p>5. Please refer to W186: The facility failed for 1 of 2 sampled clients (client A) to ensure sufficient staffing was provided to ensure supervision to prevent elopement while out in the community.</p> <p>6. Please refer to W189: The facility failed for 1 of 2 sampled clients (client A), to ensure all staff who worked with client A were sufficiently trained to assure competence in regard to the client's behavioral needs/plans.</p> <p>This federal tag relates to complaint #IN00158518.</p> <p>9-3-2(a)</p>		<p>to ensure all Individuals' IDT's meet promptly and address incidents of elopement, client to client abuse, and calling emergency services to the group home when not an emergency. The House Manager and/or QDDP will promptly report to the Area Director, per Policy, and the Area Director will monitor and ensure compliance with this Condition of Participation.</p> <p>Beginning 11/19/14 and continuing through 12/19/14, then at least every week thereafter if in compliance, QDDP, House Manager, Nurse, and/or Behaviorist have been conducting observations at least 5 times per week to ensure this Condition is being met and that all staff are consistently following the Individuals' plans and following policy/procedures.</p> <p>Will be completed by: 12/13/14</p> <p>Persons Responsible: Area Director, House Manager, QDDP, Nurse, and Behaviorist</p>		

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 2 sampled clients (clients A and B), the facility failed to implement written policy and procedures to prevent client to client aggression and to prevent client A from elopement.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records was conducted on 11/3/14 at 1:45 P.M.. Review of the facility's investigation records indicated:</p>	W000149	<p>W 149 483.420(d)(1) STAFF TREATMENT of CLIENTS</p> <p>In conjunction with the Plans of Correction for W104, W122, W154, W157, W159, W186, and W189. The Area Director, House Manager, and QDDP have reviewed this Standard. Client A's IDT met to discuss and implement protocol to prevent recurrence of Client A's client to client abuse, elopement, and calling 911 when not an emergency. All staff have been trained to ensure competency in implementing this protocol. Client A's IDT will</p>	12/13/2014

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	<p>-BDDS report dated 9/19/14 involving clients A and B indicated: "On 9/19/14 at around 9:00 A.M., [client A] came out of his room. His housemate said good morning [client A], and [client A] replied 'shut the f--k up and don't talk to me.' Staff prompted [client A] to be nice and take a deep breath. [Client A] went into the dining room area with staff following him and was looking out the window with staff behind him. [Client A] replied, 'I'm going back to my room.' Staff then followed him down the hallway leading to his room and his housemate asked 'Are you mad at me [client A]?' [Client A] then slapped his housemate. Staff intervened and [client A] ran to the bathroom and shut the door refusing to talk or come out of the bathroom for several minutes. Staff followed protocol and immediately intervened. A red mark was left on the housemate's face...."</p> <p>-BDDS report dated 10/20/14 involving client A indicated: "On 10/20/14 [client A] was out with staff for a doctor's visit and told staff he felt his blood sugar was low so staff went to [Fast food restaurant] to get him something to eat and a [diet pop]. Once in the parking lot, [client A] jumped out of the van with staff begin (sic) to follow him. [Client A] went into [Electronic store] and tried to steal a display phone but couldn't due to staff</p>		<p>monitor the effectiveness of this Protocol and meet as necessary to ensure no recurrence of Client A's elopement, abuse towards other clients, or dialing 911 when not an emergency. The Area Director, House Manager, and QDDP have been retrained on ensuring the facility implements its written policies and procedures to prevent abuse/neglect of any clients in regards to client to client aggression and client elopement; to conduct thorough investigations into any incidents of elopement and client to client aggression; to ensure sufficient/effective corrective measures are put in place to prevent recurrence of elopement and client to client abuse; to ensure staff show competence in implementing all individual plans/protocols to prevent client to client abuse and elopement; to ensure all Individuals' IDT's meet promptly and address incidents of elopement, client to client abuse, and calling emergency services to the group home when not an emergency. The House Manager and/or QDDP will promptly report to the Area Director, per Policy, and the Area Director will monitor and ensure compliance with this Standard.</p> <p>Beginning 11/19/14 and continuing through 12/19/14, then at least every week thereafter if in compliance, QDDP, House Manager, Nurse, and/or Behaviorist have been</p>				

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	<p>alerting the store about what he was attempting to do. So [client A] then left out of [Electronic store] and begins to walk towards [Department store]. Once in [Department store] he walks right back to the electronics and looked around to see who was watching him so he could attempt to try and get a display phone but couldn't. [Client A] then stole a phone case from [Department store] and staff tried to get him to return it. [Client A] then walked out of the store and went back to [Electronics store]. At [Electronics store] [client A] tried again to steal a display phone for the case but couldn't steal one so he left back out saying he was going to buy him a pop. Staff reminded him that he didn't have any money. [Client A] then walked into [Fast food restaurant] and asked a (sic) older man for a dollar. Staff tried to redirect [client A] and asked the man not to give him any money but he didn't (sic). Staff then told [client A] if he bought a pop with it that staff would take it and he told staff no you won't. [Client A] then told staff to 'stop following me' and staff explained that they couldn't. Staff continued to follow him though (sic) the drive thru of [Fast food restaurant]. [Client A] then broke out running and staff followed him back over to [Department store] and then another staff followed him in to the store and there is</p>		<p>conducting observations at least 5 times per week to ensure this Standard is being met and that all staff are consistently following the Individuals' plans and following policy/procedures.</p> <p>Will be completed by: 12/13/14</p> <p>Persons Responsible: Area Director, House Manager, QDDP, Nurse, and Behaviorist</p>				

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	<p>where he threw a router box at her to hit her in the face. [Department store] then called the police. Staff then followed [client A] as he went back over to [Fast food restaurant] and kept [client A] in line of sight. The police then arrived at [Fast food restaurant] and walked [client A] in handcuffs. [Client A] then told the police that he had a gun and that he was going to kill staff. The police then arrested him for battery. [Client A] is now in jail." Further review of the record failed to indicate the facility conducted an investigation in regard to this incident of elopement, theft, physical aggression and, threat to police he had a gun which led to client A's incarceration.</p> <p>A review of client A's record was conducted on 11/6/14 at 1:30 P.M.. Client A's Behavioral Support Plan (BSP) dated 4/14 indicated: "Results From Current Assessments and Behavioral Observation: Physical aggression: Hitting, kicking, biting, slapping, throwing objects at others, or any act that can potentially cause harm to another person if completed....Based on [client A]'s history of harming animals, the severity of this behavior could be extremely high, though at this time the severity is low. Theft: Taking items that do not belong to [client A] for personal possession. This behavior is very severe</p>						

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	<p>due to the legal and interpersonal nature. Elopement: Leaving the assigned area without notifying staff or responsible person of his intention to leave supervision prior to departing and/or leaving the assigned area or supervision by staff after being declined permission to leave the area by staff...staff should follow him and keep him within eye sight at all times....is positively correlated with the target behavior of theft....Manipulation: Verbally coercing a housemate, support staff, or community member so he can engage in another behavior....Proactive Strategies: 3. [Client A] should be prompted with healthy alternatives when making food decisions, especially soda and energy drinks. Due to [client A]'s health concerns and the concerns of the effect of caffeine on [client A] by his family and support team."</p> <p>A review of the facility's "Policy and Procedure Concerning Abuse, Neglect and Exploitation", dated 2/27/14 was conducted at the facility's administrative office on 11/6/14 at 11:00 A.M. and indicated, in part, the following: "Dungarvin believes that each individual has the right to be free from mental, emotional and physical abuse in his/her daily life....Abuse, neglect or exploitation of the individuals served is strictly</p>			

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	prohibited in any Dunganrvin service delivery setting....Physical abuse is defined as any act which constitutes a violation of the assault, prostitution or criminal sexual conduct statutes including intentionally touching another person in a rude, insolent or angry manner, willful infliction of injury, unauthorized restraint/confinement resulting from physical or chemical intervention....Emotional/verbal abuse is defined as non-therapeutic conduct which produces or could reasonably be expected to produce pain or injury and is not accidental, or any repeated conduct which produces or could reasonably be expected to produce mental or emotional distress, including communicating with words or actions in an individual's presence with intent to cause fear of retaliation, fear of confinement or restraint, cause an individual to experience emotional humiliation or distress...Neglect is defined as failure to provide appropriate care, supervision, or training, failure to provide food and medical services as needed, failure to provide a safe, clean and sanitary environment and failure to provide medical supplies/safety equipment as indicated in the individual's Individual Support Plan (ISP)....The Supervisor, or Program Coordinator/Senior Director, or his/her delegate will conduct a thorough			

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	<p>investigation of the reported incident. The investigation will include the following:</p> <ol style="list-style-type: none"> 1. Review of witnesses. 2. Any evidence or previous abuse or neglect. 3. All other evidence to determine the veracity and seriousness of the charge. <p>...The facility investigation will be completed within five (5) business days, and a summary of results of the investigation will be forwarded to the administrator within five (5) business days of the incident."</p> <p>An interview with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was conducted on 11/6/14 at 2:30 P.M.. The PD/QIDP indicated the facility's abuse/neglect policy should be followed at all times. The PD/QIDP indicated there was no written documentation to indicate an investigation was completed in regards to the mentioned incidents. The PD/QIDP indicated client A's BSP was not reviewed after the mentioned incident. The PD/QIDP indicated staff are to do 5 minute checks on client A and keep him in sight at all times. The PD/QIDP indicated staff should have followed client A's BSP and transported him back to the group home after the</p>						

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W000154	<p>483.420(d)(3)</p> <p>medical appointment. The PD/QIDP further indicated there was no documentation available for review to indicate any measures were put in place to prevent recurrence of client A's elopement.</p> <p>This federal tag relates to complaint #IN00158518.</p> <p>9-3-2(a)</p>			

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	<p>STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 1 allegation of neglect, involving 1 of 2 sampled clients (client A), the facility failed to provide written evidence a thorough investigation was conducted in regard to an incident of elopement which led to his incarceration.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records was conducted on 11/3/14 at 1:45 P.M.. Review of the facility's investigation records indicated:</p> <p>-BDDS report dated 10/20/14 involving client A indicated: "On 10/20/14 [client A] was out with staff for a doctor's visit and told staff he felt his blood sugar was low so staff went to [Fast food restaurant] to get him something to eat and a [diet pop]. Once in the parking lot, [client A] jumped out of the van with staff begin (sic) to follow him. [Client A] went into [Electronic store] and tried to steal a display phone but couldn't due to staff alerting the store about what he was attempting to do. So [client A] then left</p>	W000154	<p>W 154 483.420(d)(3) STAFF TREATMENT of CLIENTS</p> <p>In conjunction with the Plans of Correction for W104, W122, W149, W157, W159, W186, and W189. The Area Director, House Manager, and QDDP have reviewed this Standard. Client A's IDT met to discuss and implement protocol to prevent recurrence of Client A's client to client abuse, elopement, and calling 911 when not an emergency. All staff have been trained to ensure competency in implementing this protocol. Client A's IDT will monitor the effectiveness of this Protocol and meet as necessary to ensure no recurrence of Client A's elopement, abuse towards other clients, or dialing 911 when not an emergency. The Area Director, House Manager, and QDDP have been retrained on ensuring the facility implements its written policies and procedures to prevent abuse/neglect of any clients in regards to client to client aggression and client elopement; to conduct thorough investigations into any incidents of elopement and client to client aggression; to ensure sufficient/effective corrective measures are put in place to prevent</p>	12/13/2014			

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	<p>out of [Electronic store] and begins to walk towards [Department store]. Once in [Department store] he walks right back to the electronics and looked around to see who was watching him so he could attempt to try and get a display phone but couldn't. [Client A] then stole a phone case from [Department store] and staff tried to get him to return it. [Client A] then walked out of the store and went back to [Electronics store]. At [Electronics store] [client A] tried again to steal a display phone for the case but couldn't steal one so he left back out saying he was going to buy him a pop. Staff reminded him that he didn't have any money. [Client A] then walked into [Fast food restaurant] and asked a (sic) older man for a dollar. Staff tried to redirect [client A] and asked the man not to give him any money but he didn't (sic). Staff then told [client A] if he bought a pop with it that staff would take it and he told staff no you won't. [Client A] then told staff to 'stop following me' and staff explained that they couldn't. Staff continued to follow him though (sic) the drive thru of [Fast food restaurant]. [Client A] then broke out running and staff followed him back over to [Department store] and then another staff followed him in to the store and there is where he threw a router box at her to hit her in the face. [Department store] then</p>		<p>recurrence of elopement and client to client abuse; to ensure staff show competence in implementing all individual plans/protocols to prevent client to client abuse and elopement; to ensure all Individuals' IDT's meet promptly and address incidents of elopement, client to client abuse, and calling emergency services to the group home when not an emergency. The House Manager and/or QDDP will promptly report to the Area Director, per Policy, and the Area Director will monitor and ensure compliance with this Standard.</p> <p>Beginning 11/19/14 and continuing through 12/19/14, then at least every week thereafter if in compliance, QDDP, House Manager, Nurse, and/or Behaviorist have been conducting observations at least 5 times per week to ensure this Standard is being met and that all staff are consistently following the Individuals' plans and following policy/procedures.</p> <p>Will be completed by: 12/13/14</p> <p>Persons Responsible: Area Director, House Manager, QDDP, Nurse, and Behaviorist</p>	

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	<p>called the police. Staff then followed [client A] as he went back over to [Fast food restaurant] and kept [client A] in line of sight. The police then arrived at [Fast food restaurant] and walked [client A] in handcuffs. [Client A] then told the police that he had a gun and that he was going to kill staff. The police then arrested him for battery. [Client A] is now in jail." Further review of the record failed to indicate the facility conducted an investigation in regard to this incident of elopement, theft, physical aggression and threat to police he had a gun which led to client A's incarceration.</p> <p>An interview with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was conducted on 11/6/14 at 2:30 P.M.. The PD/QIDP indicated there was no written documentation to indicate an investigation was completed in regard to the allegation of neglect. The PD/QIDP further indicated the incident should have been investigated.</p> <p>This federal tag relates to complaint #IN00158518.</p> <p>9-3-2(a)</p>						

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview, for 1 of 2 sampled clients (client A), the facility failed to take sufficient/effective corrective measures to prevent client A's elopement and contacting emergency services during non-emergency situations.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records was conducted on 11/3/14 at 1:45 P.M.. Review of the facility's investigation records indicated:</p> <p>-BDDS report dated 8/29/14 involving client A indicated: On 8/29/14 [client A] left the living room and sat down with his housemate in the dining room who was</p>	W000157	<p>W 157 483.420(d)(4) STAFF TREATMENT of CLIENTS</p> <p>In conjunction with the Plans of Correction for W104, W122, W149, W154, W159, W186, and W189. The Area Director, House Manager, and QDDP have reviewed this Standard. Client A's IDT met to discuss and implement protocol to prevent recurrence of Client A's client to client abuse, elopement, and calling 911 when not an emergency. All staff have been trained to ensure competency in implementing this protocol. Client A's IDT will monitor the effectiveness of this Protocol and meet as necessary to ensure no recurrence of Client A's elopement, abuse towards other clients, or dialing 911 when not an emergency. The Area Director, House Manager, and QDDP have</p>	12/13/2014

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	<p>talking to staff. [Client A] then told his housemate to shut up while the housemate was discussing something with staff. The housemate responded don't talk to me like that and staff tried to redirect the individuals. [Client A] then said 'I say whatever I want and aint (sic) nobody going to do nothing about it. His housemate then said you can't say whatever you to me as staff was getting the housemates to leave the area. [Client A] then grabbed a plastic chair and tried to throw it at his housemate but staff intervened. [Client A] was unsuccessful with the chair so he tried to jump over the table to get to housemate but was once again redirected by staff. The housemate was out of the room and staff was able to calm [client A] down. [Client A] then walked to his bedroom and stayed there for a few minutes. A staff member was in the dining room area talking to another individual at approximately 3:25 P.M. when staff observed [County police] vehicle pull into the driveway. A single officer approached the door and asked staff if everything was alright. The officer then stated a 911 call had been made and the person stated that someone was 'F-----g with him!' The officer then said 'It's [client A] again?' Staff replied yes. Just then [client A] walked out of his room, pointed to staff and said 'Yea take that n----r to jail.' Staff told [client</p>		<p>been retrained on ensuring the facility implements its written policies and procedures to prevent abuse/neglect of any clients in regards to client to client aggression and client elopement; to conduct thorough investigations into any incidents of elopement and client to client aggression; to ensure sufficient/effective corrective measures are put in place to prevent recurrence of elopement and client to client abuse; to ensure staff show competence in implementing all individual plans/protocols to prevent client to client abuse and elopement; to ensure all Individuals' IDT's meet promptly and address incidents of elopement, client to client abuse, and calling emergency services to the group home when not an emergency. The House Manager and/or QDDP will promptly report to the Area Director, per Policy, and the Area Director will monitor and ensure compliance with this Standard.</p> <p>Beginning 11/19/14 and continuing through 12/19/14, then at least every week thereafter if in compliance, QDDP, House Manager, Nurse, and/or Behaviorist have been conducting observations at least 5 times per week to ensure this Standard is being met and that all staff are consistently following the Individuals' plans and following policy/procedures.</p>	

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	<p>A] that was inappropriate. [Client A] then looked at staff and said 'He (the officer) got a gun. He'll shoot your black a--.' Staff explained to the officer that [client A] was in a behavior and that everything was fine. [Client A] then stated 'I want to go to jail, I don't want to be here.' The officer said '[Client A] this is the best place for you.' [Client A] went on to tell the officer that he wouldn't be here long and that he already went to jail for assault and that he was going to tell the judge to put him in jail. The officer said 'That's fine just let the judge know.' After that the officer left the facility at approximately 3:30 P.M.."</p> <p>-BDDS report dated 9/2/14 involving client A indicated: "On 9/2/14 at 11:59 P.M. [Client A] asked staff to make a cigarette and staff informed him that he had smoked all of his cigarettes for the day per his plan. [Client A] then became agitated and walked out the front door to the end of the driveway with staff right behind him. Staff then redirected [client A] to go back into the house and he did. Once in the home [client A] became agitated again and threw the TV remote at the wall. Staff directed [client A] to use his coping skills. [Client A] then grabbed the house phone and called the police to come get him. Five minutes later [client A] then threw the telephone</p>		<p>Will be completed by: 12/13/14</p> <p>Persons Responsible: Area Director, House Manager, QDDP, Nurse, and Behaviorist</p>				

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	<p>at staff and tried to harm staff. Staff used blocking technique before placing [client A] in a physical restraint (arms over arms). He was in the hold for 5 minutes until he was calm enough to be released. The police then arrived and talked with [client A] and left the home after being there for only a few minutes...."</p> <p>-BDDS report dated 10/20/14 involving client A indicated: "On 10/20/14 [client A] was out with staff for a doctor's visit and told staff he felt his blood sugar was low so staff went to [Fast food restaurant] to get him something to eat and a [diet pop]. Once in the parking lot, [client A] jumped out of the van with staff begin (sic) to follow him. [Client A] went into [Electronic store] and tried to steal a display phone but couldn't due to staff alerting the store about what he was attempting to do. So [client A] then left out of [Electronic store] and begins to walk towards [Department store]. Once in [Department store] he walks right back to the electronics and looked around to see who was watching him so he could attempt to try and get a display phone but couldn't. [Client A] then stole a phone case from [Department store] and staff tried to get him to return it. [Client A] then walked out of the store and went back to [Electronics store]. At [Electronics store] [client A] tried again</p>						

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	<p>to steal a display phone for the case but couldn't steal one so he left back out saying he was going to buy him a pop. Staff reminded him that he didn't have any money. [Client A] then walked into [Fast food restaurant] and asked a (sic) older man for a dollar. Staff tried to redirect [client A] and asked the man not to give him any money but he didn't (sic). Staff then told [client A] if he bought a pop with it that staff would take it and he told staff no you won't. [Client A] then told staff to 'stop following me' and staff explained that they couldn't. Staff continued to follow him though (sic) the drive thru of [Fast food restaurant]. [Client A] then broke out running and staff followed him back over to [Department store] and then another staff followed him in to the store and there is where he threw a router box at her to hit her in the face. [Department store] then called the police. Staff then followed [client A] as he went back over to [Fast food restaurant] and kept [client A] in line of sight. The police then arrived at [Fast food restaurant] and walked [client A] in handcuffs. [Client A] then told the police that he had a gun and that he was going to kill staff. The police then arrested him for battery. [Client A] is now in jail."</p> <p>A review of client A's record was</p>						

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	<p>conducted on 11/6/14 at 1:30 P.M.. Client A's Behavioral Support Plan (BSP) dated 4/14 indicated: "Results From Current Assessments and Behavioral Observation: Physical aggression: Hitting, kicking, biting, slapping, throwing objects at others, or any act that can potentially cause harm to another person if completed....Based on [client A]'s history of harming animals, the severity of this behavior could be extremely high, though at this time the severity is low. Theft: Taking items that do not belong to [client A] for personal possession. This behavior is very severe due to the legal and interpersonal nature. Elopement: Leaving the assigned area without notifying staff or responsible person of his intention to leave supervision prior to departing and/or leaving the assigned area or supervision by staff after being declined permission to leave the area by staff...staff should follow him and keep him within eye sight at all times...is positively correlated with the target behavior of theft....Manipulation: Verbally coercing a housemate, support staff, or community member so he can engage in another behavior....Proactive Strategies: 3. [Client A] should be prompted with healthy alternatives when making food decisions, especially soda and energy drinks. Due to [client A]'s health</p>			

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	<p>concerns and the concerns of the effect of caffeine on [client A] by his family and support team."</p> <p>Further review of the records failed to indicate the facility put measures in place to prevent client A from eloping from the group home or when out in the community. Review of the record failed to indicate client A's BSP had been reviewed and addressed his contacting of emergency services during non emergency situations.</p> <p>An interview with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was conducted on 11/6/14 at 2:30 P.M.. The PD/QIDP indicated client A was released from jail on 11/6/14. The QIDP indicated the facility did not know when client was going to be released and further indicated no further measures were put in place to prevent client A from eloping from the group home or when out in the community. The QIDP indicated client A's calling emergency services during non emergency situations is not addressed in his BSP.</p> <p>This federal tag relates to complaint #IN00158518.</p> <p>9-3-2(a)</p>			

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W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based on record review and interview, the PD/Qualified Intellectual Disabilities Professional (PD/QIDP) failed for 1 of 2 sampled clients (client A), to coordinate with the Inter Disciplinary Team (IDT) and review client A's staff supervision while out in the community to prevent elopement, physical aggression and theft and to address client A's contacting of emergency services during</p>	W000159	<p>W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>In conjunction with the Plans of Correction for W104, W122, W149, W154, W157, W186, and W189. The Area Director, House Manager, and QDDP have reviewed this Standard. The QDDP/QMRP has</p>	12/13/2014

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	<p>non-emergency situations upon returning to the group home after being incarcerated.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records was conducted on 11/3/14 at 1:45 P.M.. Review of the facility's investigation records indicated:</p> <p>-BDDS report dated 2/24/14 indicated client A ran out of the van and ran into a store while out in the community with his staff and housemates. Staff followed him into the store and lost sight of him in the store and then found him.</p> <p>-BDDS report dated 4/3/14 indicated staff was preparing client A's 11:00 P.M. medications in the office. When staff went to client A's bedroom to administer the medications client A was gone. Staff noticed him walking down the road and followed him to a gas station where client A entered. Once back at the group home it was found that client A had stolen two energy drinks and two sodas. Further review of the report failed to indicate the group home is located on a country road approximately 2 miles from the gas station which is located on a major rural</p>		<p>been retrained on ensuring each client's active treatment program is integrated, coordinated, and monitored. Client A's IDT met to discuss and implement protocol to prevent recurrence of Client A's client to client abuse, elopement, and calling 911 when not an emergency. All staff have been trained to ensure competency in implementing this protocol. Client A's IDT will monitor the effectiveness of this Protocol and meet as necessary to ensure no recurrence of Client A's elopement, abuse towards other clients, or dialing 911 when not an emergency. The Area Director, House Manager, and QDDP have been retrained on ensuring the facility implements its written policies and procedures to prevent abuse/neglect of any clients in regards to client to client aggression and client elopement; to conduct thorough investigations into any incidents of elopement and client to client aggression; to ensure sufficient/effective corrective measures are put in place to prevent recurrence of elopement and client to client abuse; to ensure staff show competence in implementing all individual plans/protocols to prevent client to client abuse and elopement; to ensure all Individuals' IDT's meet promptly and address incidents of elopement, client to client abuse, and calling emergency services to the group home when not an emergency. The House Manager and/or QDDP will promptly report to the Area</p>		

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	<p>divided highway.</p> <p>-BDDS report dated 10/20/14 involving client A indicated: "On 10/20/14 [client A] was out with staff for a doctor's visit and told staff he felt his blood sugar was low so staff went to [Fast food restaurant] to get him something to eat and a [diet pop]. Once in the parking lot, [client A] jumped out of the van with staff begin (sic) to follow him. [Client A] went into [Electronic store] and tried to steal a display phone but couldn't due to staff alerting the store about what he was attempting to do. So [client A] then left out of [Electronic store] and begins to walk towards [Department store]. Once in [Department store] he walks right back to the electronics and looked around to see who was watching him so he could attempt to try and get a display phone but couldn't. [Client A] then stole a phone case from [Department store] and staff tried to get him to return it. [Client A] then walked out of the store and went back to [Electronics store]. At [Electronics store] [client A] tried again to steal a display phone for the case but couldn't steal one so he left back out saying he was going to buy him a pop. Staff reminded him that he didn't have any money. [Client A] then walked into [Fast food restaurant] and asked a (sic) older man for a dollar. Staff tried to</p>		<p>Director, per Policy, and the Area Director will monitor and ensure compliance with this Standard.</p> <p>Beginning 11/19/14 and continuing through 12/19/14, then at least every week thereafter if in compliance, QDDP, House Manager, Nurse, and/or Behaviorist have been conducting observations at least 5 times per week to ensure this Standard is being met and that all staff are consistently following the Individuals' plans and following policy/procedures.</p> <p>Will be completed by: 12/13/14</p> <p>Persons Responsible: Area Director, House Manager, QDDP, Nurse, and Behaviorist</p>				

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	<p>redirect [client A] and asked the man not to give him any money but he didn't (sic). Staff then told [client A] if he bought a pop with it that staff would take it and he told staff no you won't. [Client A] then told staff to 'stop following me' and staff explained that they couldn't. Staff continued to follow him though (sic) the drive thru of [Fast food restaurant]. [Client A] then broke out running and staff followed him back over to [Department store] and then another staff followed him in to the store and there is where he threw a router box at her to hit her in the face. [Department store] then called the police. Staff then followed [client A] as he went back over to [Fast food restaurant] and kept [client A] in line of sight. The police then arrived at [Fast food restaurant] and walked [client A] in handcuffs. [Client A] then told the police that he had a gun and that he was going to kill staff. The police then arrested him for battery. [Client A] is now in jail."</p> <p>-BDDS report dated 8/29/14 involving client A indicated: On 8/29/14 [client A] left the living room and sat down with his housemate in the dining room who was talking to staff. [Client A] then told his housemate to shut up while the housemate was discussing something with staff. The housemate responded</p>				

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	<p>don't talk to me like that and staff tried to redirect the individuals. [Client A] then said 'I say whatever I want and aint (sic) nobody going to do nothing about it. His housemate then said you can't say whatever you to me as staff was getting the housemates to leave the area. [Client A] then grabbed a plastic chair and tried to throw it at his housemate but staff intervened. [Client A] was unsuccessful with the chair so he tried to jump over the table to get to housemate but was once again redirected by staff. The housemate was out of the room and staff was able to calm [client A] down. [Client A] then walked to his bedroom and stayed there for a few minutes. A staff member was in the dining room area talking to another individual at approximately 3:25 P.M. when staff observed [County police] vehicle pull into the driveway. A single officer approached the door and asked staff if everything was alright. The officer then stated a 911 call had been made and the person stated that someone was 'F-----g with him!' The officer then said 'It's [client A] again?' Staff replied yes. Just then [client A] walked out of his room, pointed to staff and said 'Yea take that n----r to jail.' Staff told [client A] that was inappropriate. [Client A] then looked at staff and said 'He (the officer) got a gun. He'll shoot your black a--.' Staff explained to the officer that</p>			
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	<p>[client A] was in a behavior and that everything was fine. [Client A] then stated 'I want to go to jail, I don't want to be here.' The officer said '[Client A] this is the best place for you.' [Client A] went on to tell the officer that he wouldn't be here long and that he already went to jail for assault and that he was going to tell the judge to put him in jail. The officer said 'That's fine just let the judge know.' After that the officer left the facility at approximately 3:30 P.M.."</p> <p>-BDDS report dated 9/2/14 involving client A indicated: "On 9/2/14 at 11:59 P.M. [Client A] asked staff to make (sic) a cigarette and staff informed him that he had smoked all of his cigarettes for the day per his plan. [Client A] then became agitated and walked out the front door to the end of the driveway with staff right behind him. Staff then redirected [client A] to go back into the house and he did. Once in the home [client A] became agitated again and threw the TV remote at the wall. Staff directed [client A] to use his coping skills. [Client A] then grabbed the house phone and called the police to come get him. Five minutes later [client A] then threw the telephone at staff and tried to harm staff. Staff used blocking technique before placing [client A] in a physical restraint (arms over arms). He was in the hold for 5 minutes</p>						

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	<p>until he was calm enough to be released. The police then arrived and talked with [client A] and left the home after being there for only a few minutes...."</p> <p>A review of client A's record was conducted on 11/6/14 at 1:30 P.M.. Client A's Behavioral Support Plan (BSP) dated 4/14 indicated: "Results From Current Assessments and Behavioral Observation: Physical aggression: Hitting, kicking, biting, slapping, throwing objects at others, or any act that can potentially cause harm to another person if completed....Based on [client A]'s history of harming animals, the severity of this behavior could be extremely high, though at this time the severity is low. Theft: Taking items that do not belong to [client A] for personal possession. This behavior is very severe due to the legal and interpersonal nature. Elopement: Leaving the assigned area without notifying staff or responsible person of his intention to leave supervision prior to departing and/or leaving the assigned area or supervision by staff after being declined permission to leave the area by staff...staff should follow him and keep him within eye sight at all times...is positively correlated with the target behavior of theft....Manipulation: Verbally coercing a housemate, support staff, or community</p>						

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	<p>member so he can engage in another behavior....Proactive Strategies: 3. [Client A] should be prompted with healthy alternatives when making food decisions, especially soda and energy drinks. Due to [client A]'s health concerns and the concerns of the effect of caffeine on [client A] by his family and support team." Review of the record failed to indicate client A's BSP had been reviewed and addressed his contacting of emergency services during non emergency situations.</p> <p>Further review of the records failed to indicate the PD/QIDP coordinated with client A's IDT to review, address and put measures in place to protect client A from elopement when out in the community. The record failed to indicate the PD/QIDP ensured client A's BSP specifically indicated what his staffing/supervision should be while transporting and out in the community. The record failed to indicate the QIDP coordinated with client A's IDT and addressed client A's contacting of emergency services during non emergency situations.</p> <p>An interview with the PD/QIDP was conducted on 11/6/14 at 2:30 P.M.. The PD/QIDP indicated client A was released from jail on 11/6/14. The QIDP</p>						

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	<p>indicated she had not coordinated with client A's IDT to review, address and put measures in place to protect client A from elopement because the facility did not know when client was going to be released and indicated no further measures were put in place to prevent client A from eloping when out in the community. The QIDP indicated client A required two staff while transporting while out in the community to prevent him from eloping. The QIDP indicated client A's calling emergency services during non emergency situations is not addressed in his BSP.</p> <p>This federal tag relates to complaint #IN00158518.</p> <p>9-3-3(a)</p>				

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W000186	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on record review, observation and interview, the facility failed 1 of 2 sampled clients (client A) to provide sufficient numbers of direct care staff to supervise client A while out in the community.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records was conducted on 11/3/14 at 1:45 P.M.. Review of the facility's investigation records indicated:</p> <p>-BDDS report dated 10/20/14 involving client A indicated: "On 10/20/14 [client A] was out with staff for a doctor's visit and told staff he felt his blood sugar was</p>	W000186	<p>W 186 483.430(d)(1-2) DIRECT CARE STAFF</p> <p>In conjunction with the Plans of Correction for W104, W122, W149, W154, W157, W159, and W189. (Note: The QDDP was incorrect in stating that Client A's protocol required two staff to be with him while in the community. At the time of the incident, Client A required one-on-one staffing according to his plan/protocol). However, due to the incident, Client A is now required two staff while in the community to prevent elopement and/or incarceration. Area Director, House Manager, and QDDP have reviewed this Standard. The QDDP/QMRP has been retrained on ensuring each client's active treatment program is integrated, coordinated, and</p>	12/13/2014
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	low so staff went to [Fast food restaurant] to get him something to eat and a [diet pop]. Once in the parking lot, [client A] jumped out of the van with staff begin (sic) to follow him. [Client A] went into [Electronic store] and tried to steal a display phone but couldn't due to staff alerting the store about what he was attempting to do. So [client A] then left out of [Electronic store] and begins to walk towards [Department store]. Once in [Department store] he walks right back to the electronics and looked around to see who was watching him so he could attempt to try and get a display phone but couldn't. [Client A] then stole a phone case from [Department store] and staff tried to get him to return it. [Client A] then walked out of the store and went back to [Electronics store]. At [Electronics store] [client A] tried again to steal a display phone for the case but couldn't steal one so he left back out saying he was going to buy him a pop. Staff reminded him that he didn't have any money. [Client A] then walked into [Fast food restaurant] and asked a (sic) older man for a dollar. Staff tried to redirect [client A] and asked the man not to give him any money but he didn't (sic). Staff then told [client A] if he bought a pop with it that staff would take it and he told staff no you won't. [Client A] then told staff to 'stop following me' and staff		monitored. Client A's IDT met to discuss and implement protocol to prevent recurrence of Client A's client to client abuse, elopement, and calling 911 when not an emergency. All staff have been trained to ensure competency in implementing this protocol. Client A's IDT will monitor the effectiveness of this Protocol and meet as necessary to ensure no recurrence of Client A's elopement, abuse towards other clients, or dialing 911 when not an emergency. The Area Director, House Manager, and QDDP have been retrained on ensuring the facility implements its written policies and procedures to prevent abuse/neglect of any clients in regards to client to client aggression and client elopement; to conduct thorough investigations into any incidents of elopement and client to client aggression; to ensure sufficient/effective corrective measures are put in place to prevent recurrence of elopement and client to client abuse; to ensure staff show competence in implementing all individual plans/protocols to prevent client to client abuse and elopement; to ensure all Individuals' IDT's meet promptly and address incidents of elopement, client to client abuse, and calling emergency services to the group home when not an emergency. The House Manager and/or QDDP will promptly report to the Area Director, per Policy, and the Area Director will monitor and ensure compliance with this Standard.		

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	<p>explained that they couldn't. Staff continued to follow him though (sic) the drive thru of [Fast food restaurant]. [Client A] then broke out running and staff followed him back over to [Department store] and then another staff followed him in to the store and there is where he threw a router box at her to hit her in the face. [Department store] then called the police. Staff then followed [client A] as he went back over to [Fast food restaurant] and kept [client A] in line of sight. The police then arrived at [Fast food restaurant] and walked [client A] in handcuffs. [Client A] then told the police that he had a gun and that he was going to kill staff. The police then arrested him for battery. [Client A] is now in jail." Review of the record indicated one direct care staff transported client A to his medical appointment during this incident of elopement.</p> <p>A review of client A's record was conducted on 11/6/14 at 1:30 P.M.. Client A's Behavioral Support Plan (BSP) dated 4/14 indicated: "Results From Current Assessments and Behavioral Observation: Physical aggression: Hitting, kicking, biting, slapping, throwing objects at others, or any act that can potentially cause harm to another person if completed....Based on [client A]'s history of harming animals, the</p>		<p>Beginning 11/19/14 and continuing through 12/19/14, then at least every week thereafter if in compliance, QDDP, House Manager, Nurse, and/or Behaviorist have been conducting observations at least 5 times per week to ensure this Standard is being met and that all staff are consistently following the Individuals' plans and following policy/procedures.</p> <p>Will be completed by: 12/13/14</p> <p>Persons Responsible: Area Director, House Manager, QDDP, Nurse, and Behaviorist</p>	
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	<p>severity of this behavior could be extremely high, though at this time the severity is low. Theft: Taking items that do not belong to [client A] for personal possession. This behavior is very severe due to the legal and interpersonal nature. Elopement: Leaving the assigned area without notifying staff or responsible person of his intention to leave supervision prior to departing and/or leaving the assigned area or supervision but staff after being declined permission to leave the area by staff...staff should follow him and keep him within eye sight at all times...is positively correlated with the target behavior of theft....Manipulation: Verbally coercing a housemate, support staff, or community so he can engage in another behavior....Proactive Strategies: 3. [Client A] should be prompted with healthy alternatives when making food decisions, especially soda and energy drinks. Due to [client A]'s health concerns and the concerns of the effect of caffeine on [client A] by his family and support team."</p> <p>An interview with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was conducted on 11/6/14 at 2:30 P.M.. The PD/QIDP indicated only one female staff transported client A on his medical</p>						

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	<p>appointment on 10/20/14. The PD/QIDP indicated client A requires 2 staff, a driver and support staff, when transported out in the community to prevent him from eloping.</p> <p>This federal tag relates to complaint #IN00158518.</p> <p>9-3-3(a)</p>						
W000189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview for 1 of 2 sampled clients (client A), the facility failed to ensure all staff who</p>	W000189	W 189 483.430(e)(1) STAFF TRAINING PROGRAM	12/13/2014			

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	<p>worked with client A were sufficiently trained to assure competence in regard to the client's behavioral needs/plans.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records was conducted on 11/3/14 at 1:45 P.M.. Review of the facility's investigation records indicated:</p> <p>-BDDS report dated 10/20/14 involving client A indicated: "On 10/20/14 [client A] was out with staff for a doctor's visit and told staff he felt his blood sugar was low so staff went to [Fast food restaurant] to get him something to eat and a [diet pop]. Once in the parking lot, [client A] jumped out of the van with staff begin (sic) to follow him. [Client A] went into [Electronic store] and tried to steal a display phone but couldn't due to staff alerting the store about what he was attempting to do. So [client A] then left out of [Electronic store] and begins to walk towards [Department store]. Once in [Department store] he walks right back to the electronics and looked around to see who was watching him so he could attempt to try and get a display phone but couldn't. [Client A] then stole a phone case from [Department store] and staff</p>		<p>In conjunction with the Plans of Correction for W104, W122, W149, W154, W157, W159, and W186. Area Director, House Manager, and QDDP have reviewed this Standard. The QDDP/QMRP has been retrained on ensuring each client's active treatment program is integrated, coordinated, monitored, and that all staff are sufficiently trained to ensure each client's active treatment program is implemented consistently by staff. The staff person involved with the incident that led to Client A's elopement and incarceration has been trained on the Individual's revised plans/Protocol. Furthermore, all staff have been re-trained on all other clients' plans/protocol at this facility. Client A's IDT met to discuss and implement protocol to prevent recurrence of Client A's client to client abuse, elopement, and calling 911 when not an emergency. All staff have been trained to ensure competency in implementing this protocol. Client A's IDT will monitor the effectiveness of this Protocol and meet as necessary to ensure no recurrence of Client A's elopement, abuse towards other clients, or dialing 911 when not an emergency. The Area Director, House Manager, and QDDP have been retrained on ensuring the facility implements its written policies and procedures to prevent abuse/neglect of any clients in regards to client to client aggression</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G793	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/19/2014
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	<p>tried to get him to return it. [Client A] then walked out of the store and went back to [Electronics store]. At [Electronics store] [client A] tried again to steal a display phone for the case but couldn't steal one so he left back out saying he was going to buy him a pop. Staff reminded him that he didn't have any money. [Client A] then walked into [Fast food restaurant] and asked a (sic) older man for a dollar. Staff tried to redirect [client A] and asked the man not to give him any money but he didn't (sic). Staff then told [client A] if he bought a pop with it that staff would take it and he told staff no you won't. [Client A] then told staff to 'stop following me' and staff explained that they couldn't. Staff continued to follow him though (sic) the drive thru of [Fast food restaurant]. [Client A] then broke out running and staff followed him back over to [Department store] and then another staff followed him in to the store and there is where he threw a router box at her to hit her in the face. [Department store] then called the police. Staff then followed [client A] as he went back over to [Fast food restaurant] and kept [client A] in line of sight. The police then arrived at [Fast food restaurant] and walked [client A] in handcuffs. [Client A] then told the police that he had a gun and that he was going to kill staff. The police then</p>		<p>and client elopement; to conduct thorough investigations into any incidents of elopement and client to client aggression; to ensure sufficient/effective corrective measures are put in place to prevent recurrence of elopement and client to client abuse; to ensure staff show competence in implementing all individual plans/protocols to prevent client to client abuse and elopement; to ensure all Individuals' IDT's meet promptly and address incidents of elopement, client to client abuse, and calling emergency services to the group home when not an emergency. The House Manager and/or QDDP will promptly report to the Area Director, per Policy, and the Area Director will monitor and ensure compliance with this Standard.</p> <p>Beginning 11/19/14 and continuing through 12/19/14, then at least every week thereafter if in compliance, QDDP, House Manager, Nurse, and/or Behaviorist have been conducting observations at least 5 times per week to ensure this Standard is being met and that all staff are consistently following the Individuals' plans and following policy/procedures.</p> <p>Will be completed by: 12/13/14</p> <p>Persons Responsible: Area</p>	

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	<p>arrested him for battery. [Client A] is now in jail."</p> <p>A review of client A's record was conducted on 11/6/14 at 1:30 P.M.. Client A's Behavioral Support Plan (BSP) dated 4/14 indicated: "Results From Current Assessments and Behavioral Observation: Physical aggression: Hitting, kicking, biting, slapping, throwing objects at others, or any act that can potentially cause harm to another person if completed....Based on [client A]'s history of harming animals, the severity of this behavior could be extremely high, though at this time the severity is low. Theft: Taking items that do not belong to [client A] for personal possession. This behavior is very severe due to the legal and interpersonal nature. Elopement: Leaving the assigned area without notifying staff or responsible person of his intention to leave supervision prior to departing and/or leaving the assigned area or supervision but staff after being declined permission to leave the area by staff...staff should follow him and keep him within eye sight at all times...is positively correlated with the target behavior of theft....Manipulation: Verbally coercing a housemate, support staff, or community member so he can engage in another behavior....Proactive Strategies: 3.</p>		<p>Director, House Manager, QDDP, Nurse, and Behaviorist</p>	

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	<p>[Client A] should be prompted with healthy alternatives when making food decisions, especially soda and energy drinks. Due to [client A]'s health concerns and the concerns of the effect of caffeine on [client A] by his family and support team."</p> <p>A review of staff training documentation was conducted on 11/6/14 at 2:00 P.M.. Review of the staff training records indicated all staff who worked with client A were trained on his 4/14 BSP and elopement protocol.</p> <p>An interview with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was conducted on 11/6/14 at 2:30 P.M.. The PD/QIDP indicated all staff who work at the group home with client A have been trained on his BSP and elopement protocol. The PD/QIDP further indicated staff should have followed his BSP as written. The PD/QIDP indicated staff should not have stopped at the fast food restaurant. The QIDP further indicated client A manipulated the staff by saying his sugar was low and used that opportunity to elope.</p> <p>This federal tag relates to complaint #IN00158518.</p>			
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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