

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/03/2012
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NAME OF PROVIDER OR SUPPLIER  SPECTRUM COMMUNITY SERVICES OF INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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W0000	<p>This visit was for the investigation of complaint #IN00110658.</p> <p>COMPLAINT #IN00110658- SUBSTANTIATED, Federal/state deficiencies related to the allegation are cited at W149 and W157.</p> <p>Dates of Survey: July 2 and 3, 2012.</p> <p>Facility number: 012557 Provider number: 15G791 AIM number: 201017960A</p> <p>Surveyor: Tim Shebel, Medical Surveyor III</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/10/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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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W0149	<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.</p> <p>Based on record review and interview, the facility failed to implement their abuse/neglect policy for 3 of 3 reviewed incidents of elopement from the facility's property to protect 1 of 1 sampled client with an elopement history (client A).</p> <p>Findings include:</p> <p>The facility's records were reviewed on 7/2/12 at 9:17 A.M.. The following elopement incidents involving client A were reviewed:</p> <p>-On 6/21/12 at 7:30 A.M., Client A became upset and began verbally and physically aggressing toward a house mate. As direct care staff #1 blocked client A's physical aggression, client A walked out of the front door of the facility. Direct care staff #1 was able to redirect the client into the group home. Once inside the group home, client A again began to verbally and physically aggress toward her house mates and staff. Direct care staff #1 blocked client A's physical aggression toward her house mates and attempted to physically restrain the client which was unsuccessful. Client A then exited the facility. Direct care</p>	W0149	<p>At survey close, no findings were presented as a correction had already been put into place.. As noted in the findings, agency had already implemented a plan of correction by adjusting the staff schedule to add an additional staff earlier in the morning.The additional staff in the mornings is to assist in insuring that if the client elopes, the additional staff will be able to provide additional support in prevent the client from leaving the property.The IDT meets over the phone after an elopement incident. During this survey the surveyor was presented with all of the behavior plan changes that have taken place over the previous year. IDT has changed the behavior plan multiple times in an effort to find a system that works for the client, the client has also given input. Guardian and Agency has stated to BDDS that the client is not appropriately placed, BDDS has indicated that there is no other placement for the client.To make it clear - agency has not notified law enforcement, community members have contacted law enforcement. Agency attempts to handle situations due to law enforcement having the tendency to escalate situations.</p>	07/04/2012			

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	<p>staff #1 tried again to restrain client A before the client left the facility property but was "overpowered." Client A began walking down the street as direct care staff #1 followed her. Client A picked up a "big stick" as she walked and threatened to "beat staff with it." While on a neighbor's property approximately three blocks from the facility, client A lost her balance and fell to the ground. Client A then began to pick up rocks from the ground and throw them at direct care staff #1. The neighbor came out of her home to offer assistance. Direct care staff #1 told the neighbor to go back into her house. Client A then began to throw rocks at the neighbor. As the neighbor went back into her house, direct care staff #1 tried again to restrain client A but was again "overpowered" by the client. Two additional direct care staff then arrived and assisted direct care staff #1 in successfully restraining the client. The neighbor called 911. The police arrived and instructed direct care staff to release the client. Client A then attempted to hit and bite the police. The police put the client in handcuffs. As direct care staff attempted to assist client A in calming herself, EMS (Emergency Medical Services) assessed the client. After twenty minutes, direct care staff, the police, and EMS personnel escorted client A back to the group home. During the</p>			
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	<p>escort, client A continued to try to hit, scratch, and head butt the direct care staff, police, and EMS personnel. Once at the group home, direct care staff and the QDDP (Qualified Developmental Disabilities Professional) took client A to a local hospital for an evaluation "due to her threats of violence and threats of harm." While at the hospital, client A remained agitated and threatened emergency room staff and facility staff. Client A was given an injection of Ativan and Geodon (medications for anxiety and psychoses). Client A eventually calmed and was transported back to the group home. A plan to resolve indicated seeking further psychiatric interventions and adding a third staff in the early morning (6:00 A.M.) to assist if there are further elopement issues.</p> <p>-On 4/6/12 at 7:40 A.M., Client A became upset and began verbally toward direct care staff and house mates. Client A began swinging her fists at direct care staff #3 as direct care staff #3 was trying to block client A from eloping. Client A continued to escalate her aggression and continued to swing at direct care staff #3. "[Direct care staff #3] was the only staff that was able to be with [client A] due to [direct care staff #2] staying with the house mates." Client A then "bolted out the front door." Direct care staff #3 was</p>			
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	<p>tried to restrain the client "but was unsuccessful due to the level of aggression [client A] was at." Client A ran down the driveway of the facility and "continued to throw rocks and threatened to harm [direct care staff #3] with a stick." Client A continued running down the street approximately three blocks to a neighbor's yard where the client "continued to throw rocks and threaten to harm [direct care staff #3] with a stick." Client A walked onto the neighbor's porch with sticks in both hands. Direct care staff #7 then arrived and assisted direct care staff #3 in trying to de-escalate client A's behavior. As client A began calming, police arrived after receiving a call from the neighbor. Police handcuffed client A. Direct care staff #3 and #7, and the police, then escorted client A back to the group home. Client A was released from the handcuffs and escorted to her room where she calmed down. A plan to resolve indicated a team meeting would be requested for 4/9/12 and direct care staff will continue to "attempt to block/restrain [client A] from eloping."</p> <p>-On 12/25/11 at 2:45 P.M., While direct care staff #5 and client A were watching a Christmas movie, client A hit direct care staff #5 and ran out the front door of the facility. Direct care staff #5 directed direct care staff #6 to call the behaviorist</p>			
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	<p>as direct care staff #5 followed client A. Direct care staff #5 attempted to restrain client A. "[Client A] resisted the restraint and started to scratch [direct care staff #5] and thrash and was able to get out of the hold (restraint) under a minute." Approximately three blocks from the facility, a neighbor was taking trash out. Client A attempted to talk to the neighbor. As the neighbor backed away from the client, client A began to scream and cry and attempted to run towards the neighbor. At this point, direct care staff #5, along with direct care staff #6 who arrived at the scene, were able to successfully restrain client A. While direct care staff #5 and #6 were restraining client A, the neighbor called the police. The police arrived and along with direct care staff #5 and #6, escorted client A back to the group home. Once back at the group home, client A resumed her normal activities without incident. A plan to resolve indicated "at the time of the incident, [client A] was the only customer (client ) at the group home. Additional staff was on shift to assist with any incidents."</p> <p>Client A's record was reviewed on 7/2/12 at 9:53 A.M.. The review indicated client A had a history of elopement behavior. Further review indicated since 12/1/11, client A has had 11 attempted</p>			

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	<p>elopements, 2 elopements where she remained on the facility's grounds, and 3 elopements where she left the facility's grounds (6/21/12, 4/6/12, and 12/25/11). Review of current Behavior Support Plans, dated 4/30/12, indicated the plans had been modified on 12/27/11 and 4/30/12 to address specific behavioral issues associated with the 12/25/11 and 4/6/12 elopements. Further review of the client's record indicated the client possessed basic pedestrian safety skills.</p> <p>Manager #1 was interviewed on 7/2/12 at 10:03 A.M.. Manager #1 stated, "[Client A] hasn't eloped since the June 21st (6/21/12) incident. That is because we added a third staff to come in at 6:00 A.M.. Most of [client A's] elopements and elopement attempts are first thing in the morning. We used to have just two staff on at that time and when [client A] would elope or try to elope, one staff would have to stay with the other customers (clients) and the other staff would deal with [client A's] elopement. One staff is just not enough to deal with [client A] sometimes. It takes two or more staff. Now when she [client A] gets up in the morning, she knows there are more staff working to deal with her behaviors so at least for now, she appears hesitant to elope."</p>			

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	<p>The facility's records were reviewed on 7/2/12 at 10:07 A.M.. Review of the facility's staffing records indicated on 6/22/12 through 7/2/12 an extra staff has come on duty at 6:00 A.M..</p> <p>Director of Operations #1 was interviewed on 7/2/12 at 10:15 A.M.. Director of Operations indicated it was after the 6/21/12 elopement incident when the extra staff person had been scheduled to come in at 6:00 A.M.. Director of Operations #1 further indicated the extra staff has assisted deterring client A from eloping.</p> <p>The facility records were further reviewed on 7/3/12 at 8:24 A.M.. A review of the facility's "Customer Abuse Notice (policy)", no date, indicated, in part, the following: "NEGLECT - failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. * Failure to provide goods and services which has resulted in customer negative outcome."</p> <p>This federal tag relates to complaint #IN00110658.</p> <p>9-3-2(a)</p>						

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W0157	<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, the facility failed to implement effective corrective actions in regards to 3 of 3 reviewed incidents of elopement from the facility's property for 1 of 1 sampled client with an elopement history (client A).</p> <p>Findings include:</p> <p>The facility's records were reviewed on 7/2/12 at 9:17 A.M.. The following elopement incidents involving client A were reviewed:</p> <p>-On 6/21/12 at 7:30 A.M., Client A became upset and began verbally and physically aggressing toward a house mate. As direct care staff #1 blocked client A's physical aggression, client A walked out of the front door of the facility. Direct care staff #1 was able to redirect the client into the group home. Once inside the group home, client A again began to verbally and physically aggress toward her house mates and staff. Direct care staff #1 blocked client A's physical aggression toward her house mates and attempted to physically restrain the client which was unsuccessful. Client</p>			W0157	<p>At survey close, no findings were presented as a correction had already been put into place.. As noted in the findings, agency had already implemented a plan of correction by adjusting the staff schedule to add an additional staff earlier in the morning.The additional staff in the mornings is to assist in insuring that if the client elopes, the additional staff will be able to provide additional support in prevent the client from leaving the property.The IDT meets over the phone after an elopement incident. During this survey the surveyor was presented with all of the behavior plan changes that have taken place over the previous year. IDT has changed the behavior plan multiple times in an effort to find a system that works for the client, the client has also given input. Guardian and Agency has stated to BDDS that the client is not appropriately placed, BDDS has indicated that there is no other placement for the client.To make it clear - agency has not notified law enforcement, community members have contacted law enforcement. Agency attempts to handle situations due to law enforcement having the tendency to escalate situations.</p>		07/04/2012

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	A then exited the facility. Direct care staff #1 tried again to restrain client A before the client left the facility property but was "overpowered." Client A began walking down the street as direct care staff #1 followed her. Client A picked up a "big stick" as she walked and threatened to "beat staff with it." While on a neighbor's property approximately three blocks from the facility, client A lost her balance and fell to the ground. Client A then began to pick up rocks from the ground and throw them at direct care staff #1. The neighbor came out of her home to offer assistance. Direct care staff #1 told the neighbor to go back into her house. Client A then began to throw rocks at the neighbor. As the neighbor went back into her house, direct care staff #1 tried again to restrain client A but was again "overpowered" by the client. Two additional direct care staff then arrived and assisted direct care staff #1 in successfully restraining the client. The neighbor called 911. The police arrived and instructed direct care staff to release the client. Client A then attempted to hit and bite the police. The police put the client in handcuffs. As direct care staff attempted to assist client A in calming herself, EMS (Emergency Medical Services) assessed the client. After twenty minutes, direct care staff, the police, and EMS personnel escorted client			

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	<p>A back to the group home. During the escort, client A continued to try to hit, scratch, and head butt the direct care staff, police, and EMS personnel. Once at the group home, direct care staff and the QDDP (Qualified Developmental Disabilities Professional) took client A to a local hospital for an evaluation "due to her threats of violence and threats of harm." While at the hospital, client A remained agitated and threatened emergency room staff and facility staff. Client A was given an injection of Ativan and Geodon (medications for anxiety and psychoses). Client A eventually calmed and was transported back to the group home. A plan to resolve indicated seeking further psychiatric interventions and adding a third staff in the early morning (6:00 A.M.) to assist if there are further elopement issues.</p> <p>-On 4/6/12 at 7:40 A.M., Client A became upset and began verbally toward direct care staff and house mates. Client A began swinging her fists at direct care staff #3 as direct care staff #3 was trying to block client A from eloping. Client A continued to escalate her aggression and continued to swing at direct care staff #3. "[Direct care staff #3] was the only staff that was able to be with [client A] due to [direct care staff #2] staying with the house mates." Client A then "bolted out</p>			

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	<p>the front door." Direct care staff #3 was tried to restrain the client "but was unsuccessful due to the level of aggression [client A] was at." Client A ran down the driveway of the facility and "continued to throw rocks and threatened to harm [direct care staff #3] with a stick." Client A continued running down the street approximately three blocks to a neighbor's yard where the client "continued to throw rocks and threaten to harm [direct care staff #3] with a stick." Client A walked onto the neighbor's porch with sticks in both hands. Direct care staff #7 then arrived and assisted direct care staff #3 in trying to de-escalate client A's behavior. As client A began calming, police arrived after receiving a call from the neighbor. Police handcuffed client A. Direct care staff #3 and #7, and the police, then escorted client A back to the group home. Client A was released from the handcuffs and escorted to her room where she calmed down. A plan to resolve indicated a team meeting would be requested for 4/9/12 and direct care staff will continue to "attempt to block/restrain [client A] from eloping."</p> <p>-On 12/25/11 at 2:45 P.M., While direct care staff #5 and client A were watching a Christmas movie, client A hit direct care staff #5 and ran out the front door of the facility. Direct care staff #5 directed</p>						

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	<p>direct care staff #6 to call the behaviorist as direct care staff #5 followed client A. Direct care staff #5 attempted to restrain client A. "[Client A] resisted the restraint and started to scratch [direct care staff #5] and thrash and was able to get out of the hold (restraint) under a minute." Approximately three blocks from the facility, a neighbor was taking trash out. Client A attempted to talk to the neighbor. As the neighbor backed away from the client, client A began to scream and cry and attempted to run towards the neighbor. At this point, direct care staff #5, along with direct care staff #6 who arrived at the scene, were able to successfully restrain client A. While direct care staff #5 and #6 were restraining client A, the neighbor called the police. The police arrived and along with direct care staff #5 and #6, escorted client A back to the group home. Once back at the group home, client A resumed her normal activities without incident. A plan to resolve indicated "at the time of the incident, [client A] was the only customer (client ) at the group home. Additional staff was on shift to assist with any incidents."</p> <p>Client A's record was reviewed on 7/2/12 at 9:53 A.M.. The review indicated client A had a history of elopement behavior. Further review indicated since 12/1/11,</p>						

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	<p>client A has had 11 attempted elopements, 2 elopements where she remained on the facility's grounds, and 3 elopements where she left the facility's grounds (6/21/12, 4/6/12, and 12/25/11). Review of current Behavior Support Plans, dated 4/30/12, indicated the plans had been modified on 12/27/11 and 4/30/12 to address specific behavioral issues associated with the 12/25/11 and 4/6/12 elopements. Further review of the client's record indicated the client possessed basic pedestrian safety skills.</p> <p>Manager #1 was interviewed on 7/2/12 at 10:03 A.M.. Manager #1 stated, "[Client A] hasn't eloped since the June 21st (6/21/12) incident. That is because we added a third staff to come in at 6:00 A.M.. Most of [client A's] elopements and elopement attempts are first thing in the morning. We used to have just two staff on at that time and when [client A] would elope or try to elope, one staff would have to stay with the other customers (clients) and the other staff would deal with [client A's] elopement. One staff is just not enough to deal with [client A] sometimes. It takes two or more staff. Now when she [client A] gets up in the morning, she knows there are more staff working to deal with her behaviors so at least for now, she appears hesitant to elope."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G791		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/03/2012	
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	<p>The facility's records were reviewed on 7/2/12 at 10:07 A.M.. Review of the facility's staffing records indicated on 6/22/12 through 7/2/12 an extra staff has come on duty at 6:00 A.M..</p> <p>Director of Operations #1 was interviewed on 7/2/12 at 10:15 A.M.. Director of Operations indicated it was after the 6/21/12 elopement incident when the extra staff person had been scheduled to come in at 6:00 A.M.. Director of Operations #1 further indicated the extra staff has assisted deterring client A from eloping.</p> <p>This federal tag relates to complaint #IN00110658.</p> <p>9-3-2(a)</p>						