

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G419	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/31/2012
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NAME OF PROVIDER OR SUPPLIER REHABILITATION CENTER DEVELOPMENTAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 428 CYPRESS NEWBURGH, IN 47630
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W0000	<p>This visit was for the investigation of complaint #IN00113839.</p> <p>Complaint #IN00113839: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W154 and W240.</p> <p>Unrelated deficiencies cited.</p> <p>Dates of Survey: 8/15, 8/17, 8/24 and 8/31/12</p> <p>Facility Number: 000933 AIMS Number: 100239740 Provider Number: 15G419</p> <p>Surveyor: Paula Chika, Medical Surveyor III-Team Leader</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/7/12 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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W0102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Governing Body for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (E, F, G and H). The governing body failed to ensure the facility implemented its written policy and procedures to prevent neglect and/or abuse of clients. The governing body failed to ensure the facility completed thorough investigations.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The governing body failed to ensure the facility met the Condition of Participation: Client Protections for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (E, F, G and H). The governing body failed to ensure clients were not neglected due to a client's physical aggression and due to a client who was at risk for choking. Please see W122. The governing body failed to implement its written policy and procedures to prevent neglect of clients (B, C, D, E, F, G and H) due to client A's aggressive behavior toward staff. The 	W0102	<p>IDT was monitoring the behavioral situation with Client A very closely, as the change in his behavior/mental illness was triggered by the discontinuation of the medication, Trileptal. The Trileptal was discontinued due to significant medical side effects, namely reduced sodium levels. IDT was meeting and discussing multiple programmatic changes; however, IDT felt the medication changes/adjustments through consultation with the psychiatrist were the crucial component in regaining stabilization for Client A, as he had been stable on the Trileptal for many years.</p> <p>IDT met numerous times to discuss Alan's aggression and explosive episodes. During those IDT meetings, we discussed Alan's individual program plan, behavior plan (specifically his proactive/reactive strategies and communication), medication adjustments/regulation with the psychiatrist, staffing, staff interventions, home visits with his family, environmental issues specific to the group home, day program issues at ASPIRE, staff training/interactions, staff program implementation, and observations that were being completed by the Behavior</p>	09/30/2012	

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	<p>governing body failed to ensure client C felt safe/comfortable in his home due to the aggression, and to ensure administrative staff worked with the group home, in a timely manner, to ensure successful placement with client A. The governing body failed to implement its written policy and procedures to prevent neglect of client C in regard to implementing the client's program plan to prevent possible choking as the client had a history of choking. The governing body failed to conduct a thorough investigation in regard to the incidents of abuse/neglect for clients A, B and E. Please see W104.</p> <p>This federal tag relates to complaint #IN00113839.</p> <p>9-3-1(a)</p>		<p>Coordinator and Director.</p> <p>Our agency currently operates with an effective abuse/neglect policy; however, it does not specifically address significant client behaviors resulting in abuse/neglect. The above areas that were addressed with Client A, are typical interventions for this type of situation and have been effective historically for us as an agency. However, due to state citations related to this particular situation, administration has developed a more specific behavioral response policy (See attached "Atypical Behaviors Intervention Policy") for potential futuristic behavioral situations. This policy will outline specific steps/interventions and will be utilized to ensure a methodical, specific policy is followed in all similar instances. The behavioral policy will ensure all necessary steps are discussed and implemented in a timely, successive manner.</p> <p>All professional staff will be trained on the new behavioral intervention policy. The Behavior Coordinator will be responsible for implementing the policy in all relevant meetings and ensuring all areas are covered and documented appropriately.</p> <p>Administrative staff worked closely with the group home coordinators, managers, and staff</p>				

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			<p>to ensure a successful placement transition for Client A. All of Client A's programming was reviewed, with numerous changes occurring with the behavior strategy to allow the client a new start, in a new environment, with new staff. Client A has recently transitioned to another group home operated by the Easter Seals Rehabilitation Center. Client A has done well in his new setting thus far, with no noted issues of aggression towards staff or other housemates. All of the new group home staff were trained on the updated programming with focus on positive interaction and moving forward in a positive manner.</p> <p>In general, RCDS diligently works toward client-centered programming. As an agency moving forward, we feel that the implementation of the "Atypical Behavioral Intervention Policy", will allow us to be more effective and efficient in handling client behavioral issues. The behavioral intervention policy will be utilized futuristically with Client A if a behavioral problem would arise. Preventatively and systemically, the policy will prevent future behavioral issues from evolving to this level, as the comprehensiveness of behavioral discussion areas, in combination with the consistency of meetings, will ensure successful</p>	

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			<p>intervention and/or other alternatives for placement being sought in a more timely manner.</p> <p><u>ATYPICAL BEHAVIORAL INTERVENTION POLICY</u></p> <p>1. An IDT will be held immediately when a significant behavioral change occurs related to any of the following areas:</p> <ul style="list-style-type: none"> a. Psychotropic medications change as a result of medical side effects b. Severe aggression towards staff or clients resulting in potential injury c. Client inability to be successfully maintained in a day program setting d. Excessive restraint in a short span of time <p>1. During the IDT, the Behavior Coordinator will facilitate discussion in the following areas and ensure all areas are discussed/addressed:</p> <ul style="list-style-type: none"> a. Identify problem/target behaviors b. Complete an immediate functional assessment if target behavior cannot be identified readily c. Evaluate current behavior in relation to current IPP/Behavioral programming and evaluate needed updates/changes d. Review current environmental impact (i.e. group home, day program home visits, 		

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			<p>etc.) and</p> <p>evaluate for potential needed change</p> <p>e. Evaluate other housemates response to behavior (emotional distress, counseling, social skills training, etc.) and schedule individual IDT as warranted</p> <p>f. Review current staff impact (demeanor, interactions, program implementation, etc.) and evaluate potential necessary changes</p> <p>g. Evaluate staffs' emotional state (mental status, communication, counseling, through EAP, etc.)</p> <p>h. Review any potential medical issues/concerns and follow up with medical team</p> <p>i. Evaluate use of restraint (i.e. need, effectiveness, frequency, etc.). Consult with MANDT trainers as necessary</p> <p>j. Evaluate training/effectiveness of staff related to behavioral plan implementation and make changes as needed (i.e. retrain by behavior coordinator, model implementation by management, etc.)</p> <p>k. Consult with other professionals as necessary for outside input</p> <p>l. Ensure current placement is appropriate and review potential options for future</p>	

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			<p>if necessary</p> <p>m. Evaluate program implementation/staff training routinely for continued efficiency and success</p> <p>3. Routine meetings (at least weekly) will occur to review all areas of concern and discuss progress and/or need for further changes. Meetings will be held more frequently if necessary.</p> <p>1.If behavioral problem cannot be effectively managed/resolved after above areas are addressed over a period if time, and the clients and/or staff remain at high risk, BDDS will be contacted for optional related to alternative placement.</p> <p>An IDT will be held in regard to Clients B, C, D, E, F, G, and H to discuss the potential effect that Client A's aggression has had on them. IDT will develop individual programming changes as needed for each client to ensure their health and well-being in case another situation such as this would arise again.</p> <p>Specifically with Client C, an IDT was held and IDT agreed that counseling would begin immediately and his IPP was updated to include social skills training related to assertiveness and communication. IDT feels</p>	

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			<p>that the social skills training can focus on coping mechanisms and different scenarios, which will allow Client C to better understand and give him insight on how to handle this type of situation if it would arise again. This training will provide him with the knowledge and skill to hopefully feel more comfortable in his home environment or any other environment he may be in futuristically if a client would display aggressive behaviors.</p> <p>All direct care staff at Cypress will be retrained on the programming changes that have occurred for all clients. Additionally, staff will be retrained on their role in communicating behavioral issues as well as potential emotional effects that client behaviors may be having on other clients in the home.</p> <p>Systemically, all professional staff will be retrained on their roles in ensuring client behaviors are monitored closely. Also, retraining will include a focus on the other clients and the impact behaviors may be having on them emotionally as well. The IDT must meet as needed to ensure all client emotional well-being is monitored and addressed as necessary.</p> <p>In general, RCDS diligently works toward client-centered programming and</p>		

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			<p>implementation. As an agency moving forward, we feel that the implementation of the "Atypical Behavioral Intervention Policy", will allow us to be more effective and efficient in handling client behavioral issues. Preventatively and systemically, the intervention policy will address significant behavioral issues swiftly, and evaluate all areas routinely to ensure efficiency as well. This policy includes follow up related to other client's emotional well-being and ensures individual IDT's are conducted as necessary.</p> <p>Staff have been trained on numerous occasions related to Client C's high risk choking plans/programming. This programming is encompassed in numerous documents including the dining plan, behavior plan, and individual program plan. IDT met and reviewed the current programs. IDT feels the current programs are effective; however, the implementation and understanding of the programming in this specific situation is of concern. Therefore, administration agreed that all staff will be retrained by the behavior coordinator on the details of Client C's high risk choking plans. Also, IDT agreed that Client C will begin being a full one-on-one staffing, as this will</p>	

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			<p>reduce staff's distraction to other clients and prevent potential mistakes with the implementation of Client C's programming.</p> <p>Disciplinary action ensued for the staff responsible for the incident sighted in the state plan of correction. The staff clearly understands, as do all the other staff, that this client cannot be in the main area of the house when food preparation or clean-up is in process. Additionally, all staff, including management, are clearly aware that any future lack of follow through related to Client C's program implementation or one-on-one staff, will result in harsh disciplinary action up to termination due to the seriousness of the client's choking risk.</p> <p>The group home manager will also be retrained on her role to ensure that staff are following the programming diligently and correctly on a consistent basis. Preventatively, observations will be conducted five times per week for one month and then at least two times per week thereafter to ensure consistent implementation and maintaining of Client C's safety related to choking.</p> <p>All direct care staff at Cypress will be retrained on the programming changes related to Client C. They will also be made aware of the seriousness of his</p>	

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			<p>programming related to his choking and the ramifications if the programming is not adhered to.</p> <p>Systemically, all professional staff will be retrained on their roles in ensuring that programming is effective and also to ensure the programming is being implemented consistently and effectively. In general, RCDS diligently works toward client-centered programming and implementation. As an agency moving forward, we feel that the implementation of the "Atypical Behavioral Intervention Policy" will allow us to be more effective and efficient in handling client behavioral issues. Preventatively and systemically, the intervention policy will address significant behavioral issues swiftly, and will include monitoring/observations of behavioral programming to ensure efficiency and success.</p> <p>Administration met and reviewed clients A, B, and E's occurrences of client-to-client aggression. Administration reviewed and agreed our current policy is effective in this area. However, in this instance, staff in the group home failed to notify the on-call of the direct client-to-client occurrences. Therefore, all professional staff, as well as the direct support staff, will be retrained on their role related to</p>	

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			<p>client-to-client aggression. Additionally, administration developed a new protocol (See attached Client-to-Client Aggression Protocol) which outlines for the on-call person, as well as the group home coordinator, what information needs to be obtained and documented to ensure all occurrences of client-to-client aggression are investigated and reported per regulation.</p> <p>Systemically, all professional staff will be retrained on their roles related to client-to-client investigations. All professional staff will also be in-serviced on the new "Client-to-Client Aggression Protocol." Also, all direct care staff will be retrained in all homes to ensure any instances of client-to-client aggression is reported immediately to ensure swift investigation and reporting.</p> <p>In general, RCDS diligently works toward client-centered programming and implementation. As an agency moving forward, we feel that the implementation of the "Client-to-Client Aggression Protocol," will ensure client-to-client incidents are handled and investigated efficiently, while also ensuring swift implementation of client safety measures.</p>		

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			<p>immediately with information to ensure safety of clients. B) Set IDT immediately on next working day to determine additional actions needed. C) Continue investigation as needed. D) Summarize the investigation E) Contact Guardians with injury and reported</p> <p>CONCLUSION/SUMMARY OF INVESTIGATION:</p> <p>_____</p>	

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W0104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D) and for 4 additional clients (E, F, G and H), the governing body failed to exercise general policy and operating direction over the facility to ensure the facility did not neglect clients in regard to a client's aggression toward others and in regard to a client's risk for choking. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted investigations in regard to client to client abuse/aggression.</p> <p>Findings include:</p> <p>1. The governing body failed to implement its written policy and procedures to prevent neglect of clients B, C, D, E, F, G and H due to client A's aggressive behavior toward staff. The governing body neglected to ensure client C felt safe/comfortable in his home due to the aggression, and to ensure administrative staff worked with the group home, in a timely manner, to ensure successful placement with client A. The governing body failed to implement its written policy and procedures to prevent</p>	W0104	<p>An IDT will be held in regard to Clients B, C, D, E, F, G, and H to discuss the potential effect that Client A's aggression has had on them. IDT will develop individual programming changes as needed for each client to ensure their health and well-being in case another situation such as this would arise again.</p> <p>Specifically with Client C, an IDT was held and IDT agreed that counseling would begin immediately and his IPP was updated to include social skills training related to assertiveness and communication. IDT feels that the social skills training can focus on coping mechanisms and different scenarios, which will allow Client C to better understand and give him insight on how to handle this type of situation if it would arise again. This training will provide him with the knowledge and skill to hopefully feel more comfortable in his home environment or any other environment he may be in futuristically if a client would display aggressive behaviors.</p> <p>All direct care staff at Cypress will be retrained on the programming changes that have occurred for all clients. Additionally, staff will be</p>	09/30/2012			

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	<p>neglect of client C in regard to implementing the client's program plan to prevent possible choking as the client had a history of choking. Please see W149.</p> <p>2. The governing body failed to conduct a thorough investigation in regard to the incidents of abuse/neglect for clients A, B and E. Please see W154.</p> <p>This federal tag relates to complaint #IN00113839.</p> <p>9-3-1(a)</p>		<p>retrained on their role in communicating behavioral issues as well as potential emotional effects that client behaviors may be having on other clients in the home.</p> <p>Systemically, all professional staff will be retrained on their roles in ensuring client behaviors are monitored closely. Also, retraining will include a focus on the other clients and the impact behaviors may be having on them emotionally as well. The IDT must meet as needed to ensure all client emotional well-being is monitored and addressed as necessary.</p> <p>In general, RCDS diligently works toward client-centered programming and implementation. As an agency moving forward, we feel that the implementation of the "Atypical Behavioral Intervention Policy", will allow us to be more effective and efficient in handling client behavioral issues. Preventatively and systemically, the intervention policy will address significant behavioral issues swiftly, and evaluate all areas routinely to ensure efficiency as well. This policy includes follow up related to other client's emotional well-being and ensures individual IDT's are conducted as necessary.</p>	

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			<p>Administration met and reviewed clients A, B, and E's occurrences of client-to-client aggression. Administration reviewed and agreed our current policy is effective in this area. However, in this instance, staff in the group home failed to notify the on-call of the direct client-to-client occurrences. Therefore, all professional staff, as well as the direct support staff, will be retrained on their role related to client-to-client aggression. Additionally, administration developed a new protocol (See attached Client-to-Client Aggression Protocol) which outlines for the on-call person, as well as the group home coordinator, what information needs to be obtained and documented to ensure all occurrences of client-to-client aggression are investigated and reported per regulation.</p> <p>Systemically, all professional staff will be retrained on their roles related to client-to-client investigations. All professional staff will also be in-serviced on the new "Client-to-Client Aggression Protocol." Also, all direct care staff will be retrained in all homes to ensure any instances of client-to-client aggression is reported immediately to ensure swift investigation and reporting.</p>	

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			<p>plans/programming. This programming is encompassed in numerous documents including the dining plan, behavior plan, and individual program plan. IDT met and reviewed the current programs. IDT feels the current programs are effective; however, the implementation and understanding of the programming in this specific situation is of concern. Therefore, administration agreed that all staff will be retrained by the behavior coordinator on the details of Client C's high risk choking plans. Also, IDT agreed that Client C will begin being a full one-on-one staffing, as this will reduce staff's distraction to other clients and prevent potential mistakes with the implementation of Client C's programming.</p> <p>Disciplinary action ensued for the staff responsible for the incident sighted in the state plan of correction. The staff clearly understands, as do all the other staff, that this client cannot be in the main area of the house when food preparation or clean-up is in process. Additionally, all staff, including management, are clearly aware that any future lack of follow through related to Client C's program implementation or one-on-one staff, will result in harsh disciplinary action up to termination due to the seriousness of the client's choking risk.</p>		

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			<p>The group home manager will also be retrained on her role to ensure that staff are following the programming diligently and correctly on a consistent basis. Preventatively, observations will be conducted five times per week for one month and then at least two times per week thereafter to ensure consistent implementation and maintaining of Client C's safety related to choking.</p> <p>All direct care staff at Cypress will be retrained on the programming changes related to Client C. They will also be made aware of the seriousness of his programming related to his choking and the ramifications if the programming is not adhered to.</p> <p>Systemically, all professional staff will be retrained on their roles in ensuring that programming is effective and also to ensure the programming is being implemented consistently and effectively. In general, RCDS diligently works toward client-centered programming and implementation. As an agency moving forward, we feel that the implementation of the "Atypical Behavioral Intervention Policy" will allow us to be more effective and efficient in handling client behavioral issues. Preventatively and systemically, the intervention policy will address significant</p>	

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			behavioral issues swiftly, and will include monitoring/observations of behavioral programming to ensure efficiency and success.	

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W0122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based on record review and interview, the Condition of Participation of Client Protections is not met for 4 of 4 sample clients (A, B, C and D) and for 4 additional clients (E, F, G and H). The facility failed to ensure clients were not neglected due to a client's physical aggression and due to a client who was at risk for choking.</p> <p>Findings include:</p> <p>1. The facility failed to implement its written policy and procedures to prevent neglect of clients B, C, D, E, F, G and H due to client A's aggressive behavior toward staff. The facility neglected to ensure client C felt safe/comfortable in his home due to the aggression, and to ensure administrative staff worked with the group home, in a timely manner, to ensure successful placement with client A. The facility failed to implement its written policy and procedures to prevent neglect of client C in regard to implementing the client's program plan to prevent possible choking as the client had a history of choking. Please see W149.</p> <p>2. The facility failed to conduct a</p>	W0122	<p>An IDT will be held in regard to Clients B, C, D, E, F, G, and H to discuss the potential effect that Client A's aggression has had on them. IDT will develop individual programming changes as needed for each client to ensure their health and well-being in case another situation such as this would arise again.</p> <p>Specifically with Client C, an IDT was held and IDT agreed that counseling would begin immediately and his IPP was updated to include social skills training related to assertiveness and communication. IDT feels that the social skills training can focus on coping mechanisms and different scenarios, which will allow Client C to better understand and give him insight on how to handle this type of situation if it would arise again. This training will provide him with the knowledge and skill to hopefully feel more comfortable in his home environment or any other environment he may be in futuristically if a client would display aggressive behaviors.</p> <p>All direct care staff at Cypress will be retrained on the programming changes that have occurred for all clients. Additionally, staff will be retrained on their role in</p>	09/30/2012			

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	<p>thorough investigation in regard to the incidents of abuse/neglect for clients A, B and E. Please see W154.</p> <p>This federal tag relates to complaint #IN00113839.</p> <p>9-3-2(a)</p>		<p>communicating behavioral issues as well as potential emotional effects that client behaviors may be having on other clients in the home.</p> <p>Systemically, all professional staff will be retrained on their roles in ensuring client behaviors are monitored closely. Also, retraining will include a focus on the other clients and the impact behaviors may be having on them emotionally as well. The IDT must meet as needed to ensure all client emotional well-being is monitored and addressed as necessary.</p> <p>In general, RCDS diligently works toward client-centered programming and implementation. As an agency moving forward, we feel that the implementation of the "Atypical Behavioral Intervention Policy", will allow us to be more effective and efficient in handling client behavioral issues. Preventatively and systemically, the intervention policy will address significant behavioral issues swiftly, and evaluate all areas routinely to ensure efficiency as well. This policy includes follow up related to other client's emotional well-being and ensures individual IDT's are conducted as necessary.</p>				

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			<p>Administration met and reviewed clients A, B, and E's occurrences of client-to-client aggression. Administration reviewed and agreed our current policy is effective in this area. However, in this instance, staff in the group home failed to notify the on-call of the direct client-to-client occurrences. Therefore, all professional staff, as well as the direct support staff, will be retrained on their role related to client-to-client aggression. Additionally, administration developed a new protocol (See attached Client-to-Client Aggression Protocol) which outlines for the on-call person, as well as the group home coordinator, what information needs to be obtained and documented to ensure all occurrences of client-to-client aggression are investigated and reported per regulation.</p> <p>Systemically, all professional staff will be retrained on their roles related to client-to-client investigations. All professional staff will also be in-serviced on the new "Client-to-Client Aggression Protocol." Also, all direct care staff will be retrained in all homes to ensure any instances of client-to-client aggression is reported immediately to ensure swift investigation and reporting.</p>		

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			<p>_____</p> <p><u>AFTER INVESTIGATION:</u></p> <p>A) Call administrative pager immediately with information to ensure safety of clients. B) Set IDT immediately on next working day to determine additional actions needed. C) Continue investigation as needed. D) Summarize the investigation E) Contact Guardians with injury and reported</p> <p>CONCLUSION/SUMMARY OF INVESTIGATION:</p> <p>_____</p> <p>Staff have been trained on numerous occasions related to Client C's high risk choking plans/programming. This programming is encompassed in numerous documents including the dining plan, behavior plan, and individual program plan. IDT met and reviewed the current programs. IDT feels the current programs are effective; however, the implementation and understanding of the programming in this specific situation is of concern.</p>		

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			<p>Therefore, administration agreed that all staff will be retrained by the behavior coordinator on the details of Client C's high risk choking plans. Also, IDT agreed that Client C will begin being a full one-on-one staffing, as this will reduce staff's distraction to other clients and prevent potential mistakes with the implementation of Client C's programming.</p> <p>Disciplinary action ensued for the staff responsible for the incident sighted in the state plan of correction. The staff clearly understands, as do all the other staff, that this client cannot be in the main area of the house when food preparation or clean-up is in process. Additionally, all staff, including management, are clearly aware that any future lack of follow through related to Client C's program implementation or one-on-one staff, will result in harsh disciplinary action up to termination due to the seriousness of the client's choking risk.</p> <p>The group home manager will also be retrained on her role to ensure that staff are following the programming diligently and correctly on a consistent basis. Preventatively, observations will be conducted five times per week for one month and then at least two times per week thereafter to ensure consistent implementation and maintaining of Client C's</p>	

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			<p>safety related to choking.</p> <p>All direct care staff at Cypress will be retrained on the programming changes related to Client C. They will also be made aware of the seriousness of his programming related to his choking and the ramifications if the programming is not adhered to.</p> <p>Systemically, all professional staff will be retrained on their roles in ensuring that programming is effective and also to ensure the programming is being implemented consistently and effectively. In general, RCDS diligently works toward client-centered programming and implementation. As an agency moving forward, we feel that the implementation of the "Atypical Behavioral Intervention Policy" will allow us to be more effective and efficient in handling client behavioral issues. Preventatively and systemically, the intervention policy will address significant behavioral issues swiftly, and will include monitoring/observations of behavioral programming to ensure efficiency and success.</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	

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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. Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D), and for 4 additional clients (E, F, G and H), the facility neglected to implement its written policy and procedures to prevent neglect of clients due to client A's aggressive behavior toward staff. The facility neglected to ensure client C felt safe/comfortable in his home due to the aggression, and to ensure administrative staff worked with the group home, in a timely manner, to ensure successful placement with client A. The facility also neglected to implement its written policy and procedures to prevent neglect of client C in regard to implementing the client's program plan to prevent possible choking as the client had a history of choking.</p> <p>Findings include:</p> <p>1. The facility's internal incident reports, reportable incident reports and/or investigations were reviewed on 8/17/12 at 8:35 AM. The facility's internal incident reports, reportables and/or investigations indicated the following (not all inclusive):</p>	W0149	<p>IDT was monitoring the behavioral situation with Client A very closely, as the change in his behavior/mental illness was triggered by the discontinuation of the medication, Trileptal. The Trileptal was discontinued due to significant medical side effects, namely reduced sodium levels. IDT was meeting and discussing multiple programmatic changes; however, IDT felt the medication changes/adjustments through consultation with the psychiatrist were the crucial component in regaining stabilization for Client A, as he had been stable on the Trileptal for many years.</p> <p>IDT met numerous times to discuss Alan's aggression and explosive episodes. During those IDT meetings, we discussed Alan's individual program plan, behavior plan (specifically his proactive/reactive strategies and communication), medication adjustments/regulation with the psychiatrist, staffing, staff interventions, home visits with his family, environmental issues specific to the group home, day program issues at ASPIRE, staff training/interactions, staff program implementation, and observations that were being completed by the Behavior</p>	09/30/2012			

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	<p>-8/6/12 "[Client A] arrived home from day program and after putting away his belongings and toileting, he came into the kitchen to choose a snack. He chose strawberry cream cheese on crackers, which has to be softened per his diet orders. He did not want the food altered, nor did he want to wait...[Client A] became angry and began coming after staff. He pulled her hair, scratched, bit, spit, and tried pulling staff outside while telling them to 'get out.' Staff had to implement MANDT (physical restraint) restraints for their protection. Multiple holds were attempted, and they were successfully held for about 90 seconds... [Client A] has had numerous medication adjustments with minimal success being noted related to his aggression. IDT (interdisciplinary team) will continue work with [name of doctor], [client A's] psychiatrist, as we continue to strive to find a medication regimen to control his anger and aggression. Programming changes have been ineffective as well...."</p> <p>The facility's 8/6/12 Behavior Incident Report (BIR) indicated 5 staff were working at the time of the incident. The 8/6/12 BIR indicated "...[Client A] attacked multiple staff pulling hair, scratching, biting, spitting, telling them 'to get out,' and trying to physically put staff</p>		<p>Coordinator and Director.</p> <p>Our agency currently operates with an effective abuse/neglect policy; however, it does not specifically address significant client behaviors resulting in abuse/neglect. The above areas that were addressed with Client A, are typical interventions for this type of situation and have been effective historically for us as an agency. However, due to state citations related to this particular situation, administration has developed a more specific behavioral response policy (See attached "Atypical Behaviors Intervention Policy") for potential futuristic behavioral situations. This policy will outline specific steps/interventions and will be utilized to ensure a methodical, specific policy is followed in all similar instances. The behavioral policy will ensure all necessary steps are discussed and implemented in a timely, successive manner.</p> <p>All professional staff will be trained on the new behavioral intervention policy. The Behavior Coordinator will be responsible for implementing the policy in all relevant meetings and ensuring all areas are covered and documented appropriately.</p> <p>Administrative staff worked closely with the group home coordinators, managers, and staff</p>				

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	<p>outside...15 attempts at MANDT were done. 3 lasting approximately 1 1/2 minutes each. 2 person one arm standing restraints were implemented...."</p> <p>-8/1/12 at 5:50 AM, the BIR indicated only 3 staff worked during the morning shift on 8/1/12. The BIR indicated "[Client A] was getting in another resident's face (client F) and attempting to touch him while eating. Staff calmly asked [client A] to let the other resident eat and to finish his juice so he could do personal care and get dressed. [Client A] attacked staff after being asked to give the other resident space. He slapped staff, bit staff, punched staff and head butted staff. He went outside and banged on house windows, screamed and grabbed shears and threatened staff with them. He came back in and continued, hitting, biting and head butting staff. [Client A] grabbed staff and drug (sic) them into his bedroom trying to put staff on his bed. He punched his bed and furniture." The BIR indicated facility staff attempted to restrain the client 13 times "...but [client A] was too combative to be restrained...." The BIR indicated during one restraint attempt, staff were attempting to do a 2 person restraint when client A "jerked" causing staff and client A to fall to the floor in the medication room causing client A to hit the med cabinet.</p>		<p>to ensure a successful placement transition for Client A. All of Client A's programming was reviewed, with numerous changes occurring with the behavior strategy to allow the client a new start, in a new environment, with new staff. Client A has recently transitioned to another group home operated by the Easter Seals Rehabilitation Center. Client A has done well in his new setting thus far, with no noted issues of aggression towards staff or other housemates. All of the new group home staff were trained on the updated programming with focus on positive interaction and moving forward in a positive manner.</p> <p>In general, RCDS diligently works toward client-centered programming. As an agency moving forward, we feel that the implementation of the "Atypical Behavioral Intervention Policy", will allow us to be more effective and efficient in handling client behavioral issues. The behavioral intervention policy will be utilized futuristically with Client A if a behavioral problem would arise. Preventatively and systemically, the policy will prevent future behavioral issues from evolving to this level, as the comprehensiveness of behavioral discussion areas, in combination with the consistency of meetings, will ensure successful</p>		

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	<p>-7/31/12 "Another Resident (client B) had [client A's] pajama pants on. [Client A] walked up to the resident and chest shoved him." The 7/31/12 BIR neglected to indicate if the administrator had been made aware of the client to client incident, and/or if the facility had investigated the incident.</p> <p>-7/28/12 Client A had awakened from an afternoon nap when the client came into the kitchen and told staff to be quiet. The reportable incident report indicated "...Immediately after indicating for staff to be quiet, [Client A] came after staff pulling hair, hitting, kicking, biting, etc. Staff had to implement several MANDT holds, each lasting from one to three minutes. [Client A] was very upset and really no precursor was evidenced...Numerous people came in to assist in trying to calm [client A] down. The emergency on-call person came in, as well as the group home coordinator, and one of third shift staff. Generally another person coming in defuses the situation, but in these instances, it did not help...He was agitated and upset throughout the evening. IDT met on 7/30/12 to discuss the continued behavioral issues with [client A]. [Name of doctor], [client A's] new psychiatrist, is being consulted as well...." The facility's 8/3/12 follow-up</p>		<p>intervention and/or other alternatives for placement being sought in a more timely manner.</p> <p><u>ATYPICAL BEHAVIORAL INTERVENTION POLICY</u></p> <p>1.An IDT will be held immediately when a significant behavioral change occurs related to any of the following areas:</p> <ol style="list-style-type: none"> Psychotropic medications change as a result of medical side effects Severe aggression towards staff or clients resulting in potential injury Client inability to be successfully maintained in a day program setting Excessive restraint in a short span of time <p>1.During the IDT, the Behavior Coordinator will facilitate discussion in the following areas and ensure all areas are discussed/addressed:</p> <ol style="list-style-type: none"> Identify problem/target behaviors Complete an immediate functional assessment if target behavior cannot be identified readily Evaluate current behavior in relation to current IPP/Behavioral programming and evaluate needed updates/changes Review current environmental impact (i.e. group home, day program home visits, 	

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	<p>report indicated client A would "...act out with no precursor. His general demeanor appears flat and angry all the time. Almost as if he is upset the majority of the time...." The follow-up report indicated the client's IDT met and agreed with the recommendation to increase the client's Haldol (behavior) medication. The follow-up report also indicated client A's home visits on the weekend would be ending as the client's behavior was "unstable" and home visits had been a source of the client's frustration. The follow-up report indicated the client's IDT would also consider client A to visit another "...group home setting to see if the environment alone is triggering the frustration...." The follow-up report indicated client A's aggression only occurred at the group home, and "...Currently, we have increased the staffing to ensure staff's safety...."</p> <p>The facility's 7/28/12 BIR at 5:15 PM indicated 5 staff were present when the 7/28/12 incident occurred. The 7/28/12 BIR indicated client A had told facility staff to stop talking when the staff person was not talking. The BIR indicated client A was biting staff in the head, ear, and arms, kicking staff, grabbing staff's legs and attempting to bring a water hose inside the house to spray. The BIR indicated staff implemented seven 2</p>		<p>etc.) and evaluate for potential needed change e. Evaluate other housemates response to behavior (emotional distress, counseling, social skills training, etc.) and schedule individual IDT as warranted f. Review current staff impact (demeanor, interactions, program implementation, etc.) and evaluate potential necessary changes g. Evaluate staffs' emotional state (mental status, communication, counseling, through EAP, etc.) h. Review any potential medical issues/concerns and follow up with medical team i. Evaluate use of restraint (i.e. need, effectiveness, frequency, etc.). Consult with MANDT trainers as necessary j. Evaluate training/effectiveness of staff related to behavioral plan implementation and make changes as needed (i.e. retrain by behavior coordinator, model implementation by management, etc.) k. Consult with other professionals as necessary for outside input l. Ensure current placement is appropriate and review potential options for future</p>				

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	<p>person 1 arm standing restraints with one restraint lasting 15 minutes. A second BIR on 7/28/12 at 6:45 PM indicated client A was attacking a staff person and went into client F's bedroom. The BIR indicated when client F asked client A to leave his bedroom, client A "forcefully put his hand on [client F's] shoulder and yelled at him, yelling & (and) hitting staff in the head (sic)." The BIR indicated facility staff restrained the client 5 different times using a Mandt 2 person 1 arm standing restraint. A third BIR at 7:30 PM, on 7/28/12, indicated "[Client A] stayed agitated from a previous behavior. He followed a particular staff into the small bathroom and attacked her." The BIR indicated facility staff attempted 4 restraint holds to attempt to calm the client with only one of the holds being successful for 45 seconds. The BIRs indicated client A's behavior lasted from 5:15 PM to 7:40 PM. The above mentioned BIRs indicated client H was sitting in the living room waiting to be changed from 7:30 PM to 7:40 PM and client C was in the "Big bathroom sitting in the shower..." from 5:15 PM to 6:05 PM. The 7/28/12 reportable incident report neglected to indicate the facility conducted an investigation in regard to the client to client incident.</p> <p>-7/17/12 "At dinnertime, [client A] did</p>		<p>if necessary</p> <p>m. Evaluate program implementation/staff training routinely for continued efficiency and success</p> <p>3. Routine meetings (at least weekly) will occur to review all areas of concern and discuss progress and/or need for further changes. Meetings will be held more frequently if necessary.</p> <p>1.If behavioral problem cannot be effectively managed/resolved after above areas are addressed over a period if time, and the clients and/or staff remain at high risk, BDDS will be contacted for optional related to alternative placement.</p> <p>An IDT will be held in regard to Clients B, C, D, E, F, G, and H to discuss the potential effect that Client A's aggression has had on them. IDT will develop individual programming changes as needed for each client to ensure their health and well-being in case another situation such as this would arise again.</p> <p>Specifically with Client C, an IDT was held and IDT agreed that counseling would begin immediately and his IPP was updated to include social skills training related to assertiveness and communication. IDT feels</p>				

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	<p>not want to set the table. He got up and walked toward the Group Home Manager in the kitchen. He grabbed for her hair and continued aggressively grabbing. Two other staff implemented a MANDT hold (for 1 minute) and he dropped to the ground out of the hold. [Client A] then tried to grab another staff. Staff placed him in another MANDT hold two more times for 45 seconds each...." The facility's 7/20/12 follow-up report indicated client A attempted to grab a hot pan of rice from the manager during the incident. The follow-up report indicated client A's medication was increased on 7/19/12.</p> <p>The facility's 7/17/12 BIR indicated facility staff implemented a Mandt restraint 4 times and each time client A fell to the floor causing staff to release the restraint and client A would aggress against staff again. The BIR indicated 5 staff were working at the time the incident occurred.</p> <p>-6/21/12 "[Client A] became agitated after arriving home from day program. He was coming back down the hallway and staff was trying to turn on the light. He just came towards staff grabbing at their face and pulling hair. [Client A] went after all staff of (sic) shift and was seeking them out. He required approximately 10</p>		<p>that the social skills training can focus on coping mechanisms and different scenarios, which will allow Client C to better understand and give him insight on how to handle this type of situation if it would arise again. This training will provide him with the knowledge and skill to hopefully feel more comfortable in his home environment or any other environment he may be in futuristically if a client would display aggressive behaviors.</p> <p>All direct care staff at Cypress will be retrained on the programming changes that have occurred for all clients. Additionally, staff will be retrained on their role in communicating behavioral issues as well as potential emotional effects that client behaviors may be having on other clients in the home.</p> <p>Systemically, all professional staff will be retrained on their roles in ensuring client behaviors are monitored closely. Also, retraining will include a focus on the other clients and the impact behaviors may be having on them emotionally as well. The IDT must meet as needed to ensure all client emotional well-being is monitored and addressed as necessary.</p> <p>In general, RCDS diligently works toward client-centered programming and</p>				

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	<p>MANDT restraints which were held for about one minute each as [client A] would drop to the ground requiring the hold to be released...[Name of doctor] recommended the increase of Cymbalta (behavior) and wants that to be tried for about three weeks. If the increase is not found to be successful, he stated that the Trileptal (behavior) may be reintroduced in combination with a sodium pill...."</p> <p>The facility's 6/28/12 follow-up report indicated the facility staff utilized a two person restraint technique with the client, and had tried medication changes and "numerous" program/behavior changes which did not prove to be successful. The follow-up report indicated client A would start going to work earlier with another client (client C) and return home from work/day program at a different time and decrease the known times client A would get upset.</p> <p>The facility's 6/21/12 BIR indicated "[Client A] became physical he was grabbing pulled one staff's hair 4 times, another staff's hair 5 times he bit one staff 3 times and another staff 2 times, spitting in staff's face (sic). yelling (sic), tried pulling staff onto a bed, then tried to pull one staff onto the couch, kept telling them to leave,...and threw 2 different objects at staff. When staff would restrain would fall to the floor then grab at their</p>		<p>implementation. As an agency moving forward, we feel that the implementation of the "Atypical Behavioral Intervention Policy", will allow us to be more effective and efficient in handling client behavioral issues. Preventatively and systemically, the intervention policy will address significant behavioral issues swiftly, and evaluate all areas routinely to ensure efficiency as well. This policy includes follow up related to other client's emotional well-being and ensures individual IDT's are conducted as necessary.</p> <p>Staff have been trained on numerous occasions related to Client C's high risk choking plans/programming. This programming is encompassed in numerous documents including the dining plan, behavior plan, and individual program plan. IDT met and reviewed the current programs. IDT feels the current programs are effective; however, the implementation and understanding of the programming in this specific situation is of concern. Therefore, administration agreed that all staff will be retrained by the behavior coordinator on the details of Client C's high risk choking plans. Also, IDT agreed that Client C will begin being a full</p>				

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	<p>legs...Staff was also pulled outside and fell in the rose bushes, continued to try and attack staff from beginning of incident-Would try to get where they are at- Which was with other residents."</p> <p>-6/16/12 "[Client A] was mocking another resident (client E) & getting in their face. Staff tried to redirect [client A] asking him to put his socks on. [Client A] then attacked staff. [Client A] hit, pinched, pulled staff's hair, told staff to leave, hit, told resident to leave, got in resident's face, tried dragging staff out of house, kicked staffstaff implemented 10 Mandt holds...Staff tried talking to [client A] to calm him down which was unsuccessful. Staff called pager. The BIR indicated only 2 staff were working in the group home at 6:15 AM when the incident occurred. The BIR indicated facility staff implemented a 2 person 1 arm restraint while client B was sitting in the dining room area and client C was in his room getting dressed. The BIR indicated the other clients were in their bedrooms sleeping.</p> <p>A 6/16/12 BIR at 9 AM indicated 3 staff were working at the group home and client A had a behavior which lasted from 9 AM to 11 AM. The BIR indicated "[Client A] was constantly in another residents (sic) (client E) face. Yelling at</p>		<p>one-on-one staffing, as this will reduce staff's distraction to other clients and prevent potential mistakes with the implementation of Client C's programming.</p> <p>Disciplinary action ensued for the staff responsible for the incident sighted in the state plan of correction. The staff clearly understands, as do all the other staff, that this client cannot be in the main area of the house when food preparation or clean-up is in process. Additionally, all staff, including management, are clearly aware that any future lack of follow through related to Client C's program implementation or one-on-one staff, will result in harsh disciplinary action up to termination due to the seriousness of the client's choking risk.</p> <p>The group home manager will also be retrained on her role to ensure that staff are following the programming diligently and correctly on a consistent basis. Preventatively, observations will be conducted five times per week for one month and then at least two times per week thereafter to ensure consistent implementation and maintaining of Client C's safety related to choking.</p> <p>All direct care staff at Cypress will be retrained on the programming changes related to Client C. They will also be made aware of</p>		

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	<p>him, taking his Leggos (sic) and boomwhacker, making fun of him following him around. [Client A] was also continuously touching the other resident." The BIR indicated client E stated "...[Client A] is pestering me' and continued to say '[Client A] you're mean.'" Staff asked that resident if he was hurt & he said no. Staff just kept attempting to redirect [client A]."</p> <p>-6/15/12 Client A hit staff in the arm and when explained he should not hit people, client A pulled staff's hair, bit staff, yelled, swung a blanket at staff, attempted to get a knife and hit staff with a box. The 6/15/12 BIR indicated maintenance staff was in the group home and attempted to redirect the client to help them unload the supply truck. The BIR indicated "Staff attempted multiple Mandt holds...."</p> <p>-6/13/12 "[Client A] pulled staff's hair, slapped staff in the face, grabbed staff's clothing, punched staff, threw staff on the ground, pushed staff against the walls...spit in staff's face and slammed his fists down on tables and walls....Staff unsuccessfully attempted 13 MANDT holds. Staff successfully implemented 3 two person side body hug restraints...and 2 one person-two arm standing restraints...." The BIR indicated the</p>		<p>the seriousness of his programming related to his choking and the ramifications if the programming is not adhered to.</p> <p>Systemically, all professional staff will be retrained on their roles in ensuring that programming is effective and also to ensure the programming is being implemented consistently and effectively. In general, RCDS diligently works toward client-centered programming and implementation. As an agency moving forward, we feel that the implementation of the "Atypical Behavioral Intervention Policy" will allow us to be more effective and efficient in handling client behavioral issues. Preventatively and systemically, the intervention policy will address significant behavioral issues swiftly, and will include monitoring/observations of behavioral programming to ensure efficiency and success.</p>				

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	<p>incident occurred during the morning shift when 3 staff worked in the group home. The BIR indicated facility staff had encouraged client A to finish his juice per the speech pathology instructions following breakfast.</p> <p>-6/12/12 "[Client A] became aggressive with staff after they asked him to finish his juice. He was going at staff trying to hit, kick, bite, etc...Several restraints were required in order for [client A] to calm down...He continually goes after people when he is angry...He has had numerous behaviors recently requiring restraint. His Seroquel (behavior) was recently increased by [name of doctor], and there is potential that it is having a negative effect...." The 6/12/12 reportable incident report indicated the client's psychiatrist decreased the Seroquel and increased the client's Cymbalta (behavior)"... in an attempt to stabilize [client A's] mood...."</p> <p>-6/8/12 Client A became upset with staff and started hitting and "physically attacked staff." The BIR indicated other clients were removed from the dining room to a "safe area" and the pager was called for assistance.</p> <p>-6/6/12 Client A punched and hit staff, bit staff and grabbed the staff's legs. The BIR indicated staff attempted 5 Mandt</p>			

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	<p>holds with 2 being successful. The 6/6/12 incident occurred during the morning shift with 3 staff when 3 staff were working.</p> <p>The facility's 6/6/12 BIR at 6:05 AM, indicated client A was "stalking the med passer." The BIR indicated "[Client A] hit staff in the face, pulled staff's hair, slammed staff into the wall and spit in staff's face. The BIR incident report indicated 4 staff worked at the time the incident occurred and client G was waiting to get his bath. A 6/6/12 BIR at 6:23 AM indicated client A also knocked a staff person to the floor during the behavioral incident.</p> <p>-6/2/12 "[Client A] was getting settled in from his arrival home from day program. As he walked past a staff member, he hit her on the arm. Staff explained to [client A] that he should not hit others. [Client A] became upset and began pulling staff's hair, biting staff and himself, yelling, kicking, etc. Staff tried a variety of things to attempt to redirect [client A] and calm him down; however, he continued to be aggressive. Staff implemented several one-minute MANDT holds in order to assist [client A] to calm down."</p> <p>-5/23/12 When staff asked client A to come back into the dining room to finish his juice, "...[Client A] immediately</p>						

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	<p>became angry trying to smack staff, pulled hair, and spit on staff. [Client A] was very aggressive and coming after staff. Therefore, staff placed him in a MANDT hold (two person hold), per his behavior strategy...Three restraints were implemented and each one was only held for about a minute as [client A] would drop to the floor, which requires staff to release the hold...He continues to struggle since the discontinuation of his Trileptal (behavior)...Numerous programming changes have proven ineffective. We continue to work with [client A] from a programming standpoint to try and figure out if something will assist him in calming down without becoming aggressive...."</p> <p>-5/17/12 Client A hit staff in the arm and when staff told client A that he should not hit others, the client attacked staff and physically tried to punch the staff person out of the room. The BIR indicated 3 staff were working at the time, and Mandt was attempted but not successful. The BIR indicated "Staff intervened by trying to redirect [client A] & remaining other residents from harm."</p> <p>-4/27/12 Client A became upset when redirected to sit on toilet to let an enema work. The BIR indicated client A punched staff, spit in staff's face, bit staff</p>				

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	<p>on the head and arm and yelled at staff. The BIR indicated client A "forced staff outside the house" where he attacked staff again. The BIR indicated 4 staff were working when the incident occurred. The BIR incident report indicated client E was waiting to walk in his gait trainer.</p> <p>-4/8/12 "[Client A] had aggressive behaviors on Sunday that required physical restraint (MANDT) by staff. Another client was being redirected by staff and [client A] began yelling at the other client. At that time, [client A] became very aggressive. He pulled staff's hair, yelled, bit staff, bit self, spit at staff, etc...Approximately six holds were done, each lasting about 60 to 90 seconds...."</p> <p>The 4/8/12 reportable incident report indicated client A would drop to the floor once staff initiated the MANDT hold requiring the staff to release him. The reportable incident report indicated client A again became upset and began hitting, spitting and pinching staff. The reportable incident report indicated 10 holds were initiated during the second incident. The reportable incident report indicated "...IDT (interdisciplinary team) also agreed to in-service all staff to ensure they are redirecting [client A] in a way that does not reinforce what he is doing. For example, when [client A] is yelling at another resident, rather than redirecting</p>			

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	<p>him by saying to stop yelling, staff will just say, 'Come on [client A], let's go find something else to do'...."</p> <p>The facility's 4/8/12 BIR at 5:07 PM indicated "[Client A] hit, bit, pinched, & spit at staff. He pulled staff's hair, head butted staff, & slammed staff's head into wall...." The BIR indicated staff attempted to physically restrain client A 10 times which were successful and all other clients were moved to a safe place.</p> <p>A 4/8/12 BIR at 3:05 PM indicated client A started yelling at another client and when redirected started hitting staff, pulling staff's hair and attempted to bite the staff's forehead. The BIR indicated 3 staff were working at the time of the incident. The BIR also indicated client A was restrained 6 times utilizing a 2 person restraint.</p> <p>-4/5/12 Client A grabbed and pushed staff out of the med room when they were working with another client. The BIR indicated when the staff person attempted to return to the med room, client A attacked staff until a non targeted staff was able to talk/get the client to calm down.</p> <p>-3/4/12 Client A refused to take his 6 PM medications and the client began to spit at</p>						

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	<p>staff. The reportable incident report indicated "...He (client A) then got up and began charging at staff, trying to bite, pull hair, punch, etc. Staff attempted MANDT holds and were able to hold three different hold (sic) for approximately two minutes each. However, [client A] continued to be aggressive. The on-call person was contacted and arrived at the home around 6:30 PM...[Client A] and the team continue to work with [name of psychiatrist] to regulate his medications. [Client A] started his new medicine, Depakote (behavior), on 2/25/12...."</p> <p>The facility's 3/4/12 BIR indicated client A pulled his pants down, pulled staff's pants down, attempted to punch staff, scratched staff, attempted to throw furniture, pulled staff's hair and spit at staff. The BIR indicated staff attempted 10 Mandt holds and called the pager for assistance with client A's behaviors. The 3/4/12 BIR indicated clients were removed from common areas of the house for their safety.</p> <p>-2/24/12 "[Client A] arrived home from day program agitated. Staff tried to involve him in a variety of activities/chores, and also offered him the opportunity to choose an activity in order to relax in his room to calm down. [Client A] really did not choose to</p>						

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	<p>participate in anything and he continued to pace and get in staff's face. When staff were preparing snack, [client A] suddenly came at staff grabbing their hair, pinching, kicking, biting, etc...." The reportable incident report indicated 3 MANDT holds were implemented, but client A would drop to the floor causing staff to release the client. The reportable incident report indicated client A would then go after staff when they released him. The 2/24/12 reportable incident report indicated the staff called for an "external distraction" (outside person come in to talk with the client/diffuse. The reportable incident report indicated "...The holds are minimally effective due to [client A] dropping to the ground; however, no other alternative has been found as staff must attempt to hold him or he will continue to hurt them. IDT will continue to monitor [client A] as medication changes are attempted once again in attempt to regulate his explosive behaviors." The reportable incident report indicated client A's increased aggression was due to a medication change (discontinuation) of Trileptal (behavior) due to low sodium level/medical. The reportable incident reports indicated Depakote (behavior) was implemented to see if the medication would have the same effect as the Trileptal. The facility's 3/1/12 follow-up</p>			

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	<p>report indicated client A's IDT had discussed options other than the MANDT holds since client A would drop to the floor/ground. The reportable incident report indicated "...IDT discussed trying to allow him time in his room but he will not stay or redirect to that area. IDT also discussed trying to give him space just to calm down, but he charges at staff showing aggressive behavior which requires us to at least attempt to restrain him. The clients are removed from whatever area [client A's] behaviors are occurring to maintain their safety. One staff monitors the clients, while the other two staff work with [client A] to calm him down...."</p> <p>-1/21/12 Client A became upset with staff when he wanted more food at breakfast and staff told him he would have to wait until they pureed his food before he could eat it. The reportable incident report indicated "...Once staff said this, [client A] instantly became aggressive. He began pulling hair, biting staff, biting himself, throwing objects, and head butting. Staff followed his behavior plan and implemented MANDT holds five times for approximately two minutes each to try and help [client A] calm down. After approximately 45 minutes, [client A] was finally able to calm down...."</p>			

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	-1/7/12 Client A returned from a home visit with his mother and client A was "very amped up." The reportable incident report indicated "...He was pacing and getting into staff's face and personal space. He was also pointing right into people's faces...He (client A) placed both of his arms around the clients (sic) neck from behind like he was going to give him a hug. Staff immediately redirected [client A] in a calm voice that he needed to give [client E] his space. [Client A] immediately became enraged and began coming after staff. He was hitting, grabbing, pulling hair, kicking and etc. He targets all staff. Staff had to implement several two person Mandt holds attempting to calm him down; however, he kept going down to the floor requiring them to release. [Client A] is very difficult to restrain...the restraints were only minimally effective...Due to continued issues with [client A], IDT is very concerned as programming changes have no effect with his rage issues. Also, we have not been able to pinpoint a specific cause...." The 1/12/12 follow-up report indicated "...The restraint that is used with [client A] is a two person Mandt hold and he is on his feet and leaned forward in the hold. However, he is tall and strong, and generally he is able to fall to the floor which requires staff to release the hold....." The follow-up report			

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	<p>indicated program changes were made and client A was started on another behavioral medication (Seroquel). The follow-up report indicated "...Observations will also be conducted at Cypress to observe staff interactions with [client A] to ensure their phrasing of requests is done in a non-demanding way...IDT has several ideas to try with [client A]; however, we feel that the most critical component is the medication as nothing else has really changed at the group home..."</p> <p>-1/1/12 "[Client A] was in the living room making fun of another client who was becoming upset...When staff attempted to redirect him, [client A] became very upset and aggressive. He began hitting, kicking, punching, etc...." The reportable incident report indicated the client was restrained with MANDT and had to be restrained again due to the client's continued aggression which resulted in another 9 holds being used. The 1/1/12 reportable incident report indicated client A was again restrained after the client had his shower as the client aggressed against the staff. The reportable incident report indicated "...He is very volatile when he is angry and intends to really hurt someone. He often requires an outside person to come into the home to finally calm down...." The facility's 1/6/12 follow-up</p>			

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	<p>report indicated "...He is very strong when he becomes aggressive and even with two people he is difficult to hold as he drops to the ground and at that point the restraint has to be released. However, the IDT has discussed the fact that [client A] drops to the ground but due to the significance of his behavior and how he targets people to aggress towards, no other mechanism of redirection works other than restraint...."</p> <p>-12/9/11 Client A became upset when the phone rang and the phone call was not for him. The reportable incident report indicated "...He began pacing and getting into people's faces....[Client A] would not redirect and continued to be agitated. [Client A] ripped his shirt and at that point staff tried to redirect him to his room to calm down and change. [Client A] became aggressive trying to hit staff, pull hair, etc. Staff immediately implemented a two person mandt hold which was held for approximately three minutes to allow [client A] to calm down. After the hold, staff attempted to let go, but [client A] again began hitting out, kicking, pushing, etc. Staff did three more Mandt holds which lasted approximately one to two minutes [client A] was able to regain control of his anger...." The facility's 1/6/12 follow-up report indicated client A's IDT met on</p>			

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	<p>12/12/11 and discussed "...He has not been stable since he has had medication alterations due to medical issues with his sodium levels being low...."</p> <p>-11/27/11 "[Client A] came to the kitchen after waking up on 11/27/11. He immediately put his face right against staff's face. Staff redirected him, per his behavior strategy, to maintain personal space. [Client A] became very agitated, bit his wrist, and then hit staff. Staff immediately implemented a two-person side MANDT restraint for approximately one minute to allow [client A] to calm down...The restraint assists [client A] in deescalating, as when he becomes aggressive he is generally unable to regain control...."</p> <p>-11/16/11 "[Client A] was obsessing on a staff member during the afternoon on 11/16/11...Around 4:40 PM, the group home manager verbally redirected [client A] to another task due to him following this staff so closely and when she redirected, he began physically attacking. He lunged toward the manager clawing at her chest and face and tried to pull her hair. He was also attempting to bite...." The reportable incident report indicated client A was placed in a two person MANDT restraint. The reportable incident report indicated when the client</p>						

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	<p>was released ...[Client A] then would begin attacking staff again. Therefore, the restraint had to be implemented 4 more times...until [client A] did finally calm down." The reportable incident report indicated the client's psychiatrist was being "...consulted due to the frequency and intensity of his aggression increasing over the last few months..."</p> <p>During the 8/24/12 observation period between 6:05 AM and 8:00 AM, at the group home, client C was placed at the counter across from client A to eat his breakfast. Client C hesitantly looked at client A while sitting across from the client at the kitchen counter. At 6:45 AM, clients A and C rode on the same van to go to their day programs/workshop. Client C's demeanor appeared flat and the client was not as talkative as he had been in the past.</p> <p>Confidential interview F indicated client A's aggressive behavior had been going on for over a year and a half.</p> <p>Confidential interview F indicated the facility had increased staffing at the home due to the client's behavior. Confidential interview F indicated clients had been left sitting unattended, client C had been left in the shower and a client had sat wet in their adult diaper due to client A's behavior as all staff were trying to deal</p>						

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	<p>with client A. Confidential interview F indicated this was not fair to the other clients and this had occurred on 7/28/12 as client A required all staff and outside staff, who were called in, to deal with the client's behavior as the behavior lasted over 2 hours. Confidential interview F indicated even though program changes had been done, the client's behavior had not improved. Confidential interview F stated client C was "scared of [client A]" and would get upset when the client had a behavior. Confidential interview F indicated client A was sent on a visit to another group home for 10 days but had since returned to the group home.</p> <p>Confidential interview G indicated client A was on a visit at another group home. Confidential interview G stated client A had slammed a staff person's head into the window of the van during his initial visit at the group home as he wanted a donut before the texture could be modified per his doctor's order. Confidential interview G indicated client A had demonstrated aggression toward others (mainly staff) for over a year when the client's Trileptal was discontinued due to low sodium levels. Confidential interview G stated the client's behavior had not "been back on track." When asked how the other clients felt about client A, confidential interview G stated "They seem</p>			

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	<p>intimidated to me when he has behaviors." The other clients are around watching. [Client C] goes back to - his room. Staff gets everyone out of way or to the medication room and close the door to be safe." When asked if there had been any time the facility did not have enough staff to meet the needs of the clients, when client A was having a behavior, confidential interview G stated "Sure there has been times there was not enough staff."</p> <p>Client A's record was reviewed on 8/24/12 at 8:30 AM. Client A's Quarterly Nursing Summaries for 2012 indicated client A's psychiatrist made medication changes/adjustments on 1/10/12, 2/10/12, 2/24/12, 3/23/12, 3/9/12, 5/25/12, 6/9/12, 6/13/12, 6/22/12, 7/10/12, 7/18/12 and 8/9/12.</p> <p>Client A's Nurses' Notes indicated the following (not all inclusive):</p> <p>-7/18/12 Client A was reportedly getting more agitated at day program. The note indicated the Director would notify the psychiatrist of the client's increased behavior.</p> <p>-2/15/12 Client A was demonstrating attention seeking behavior and becoming agitated when staff worked with other</p>						

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	<p>clients. The note indicated "particular clients noise levels" may be escalating the client's behavior as client A appeared calmer in a quiet environment.</p> <p>-2/10/12 Client A upset and aggressive with manager. Staff unable to get the client to calm down. Male staff called from another group home to assist. The note indicated the nurse called doctor's office for an order to sedate client A. The note indicated client A's Seroquel was increased and staff was to administer a 100 milligram dose "Stat" (right now).</p> <p>Client A's record indicated the following IDT Meeting Records (not all inclusive):</p> <p>-8/2/12 "IDT met to discuss [client A's] visiting [name of group home] in order to try and determine if his behaviors stem from environmental factors, specifically Cypress. [Name of group home] staff will be inserviced on his beh (behavior) strategy, dining plan, general infor (information), IPP, etc. This visit will be temporary...placement in another group home will be sought if the visit at [name of group home] goes well."</p> <p>-6/26/12 "IDT met due to [client A's] increased intensity of his behaviors... [Client A] recently injured two staff during his aggressive behaviors...IDT</p>						

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	<p>discussed the possibility of needing an IM (Intramuscular) PRN (as needed) medication, however, the team agreed to implement the following ideas prior to implementing a PRN medication. Staffing will be increased to 4 staff and this staff person will be a floater with their main purpose to be to redirect [client A] when needed. This staff will also be provided through the other group homes. His time in the home during the weekdays will also be shortened. He will leave on the first van that comes to Cypress, and he will stay longer at [name of day program] and leave with the last load."</p> <p>-4/9/12 Client A's IDT met to review the 2 aggressive incidents on 4/8/12. The IDT note indicated client A would continue to go to counseling every 2 weeks, and indicated "...IDT also agreed to inservice staff on how to redirect him by not eluding to what could be a sensitive area or become an issue and for staff to limit talking to him when he does become aggressive...Other things that were discussed that may have to take place in the future if his aggressive behaviors do not further decrease could be limiting his home visits and/or pulling staff that he targets out of the home for a period of time."</p>			

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	<p>-2/28/12 Client A's IDT met to follow-up and review all of the programming that had been implemented and attempted with client A as the client "...continued having explosive aggressive behaviors...." The note indicated a male staff would be switched out to work at the group home on Fridays as the client was having behaviors on Friday. The IDT note indicated more program changes were made in regard to staff taking the client on walks as soon as he got off the van and the use of a communication board was implemented. The staff were to continue to remove other clients when client A became upset and call "extra staff" or management staff for assistance.</p> <p>-1/9/12 "IDT met to discuss [client A's] recent behavioral issues where he continues to become aggressive towards staff and require MANDT restraint...IDT agrees that the most important part of getting [client A] under control behaviorally is to regulate his medications again, because he has been more behavioral since his Trileptal had to be discontinued due to low sodium levels...IDT also discussed staff interactions and word phrasing with [client A]. These are both so critical. Due to [client A's] recent aggression, staff are more timid towards him</p>						

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	<p>currently. We also feel that the current situation may make staff more apt to redirect in a frustrated tone. We want to do observations and see how people are interacting with him and offer feedback/retraining based on the findings of the observations. IDT discussed that we need to ensure phrasing is done in a non-demanding way,...as well as ensuring staff are offering minimal verbal cues if another source of redirection is available (i.e. sign, picture cue, etc), as the excessive amount of verbal redirection may be overwhelming to [client A]...." The IDT also looked at more program changes.</p> <p>-1/4/12 IDT met to discuss incident on New Year's Day where client A "...had an explosive aggressive outburst...IDT discussed the difficulty of restraining him as he falls to the ground to get out of a hold. However, he must be restrained to prevent him from hurting someone. He is very persistent towards staff when he gets to a certain point...."</p> <p>Client A's 3/29/12 Individual Program Plan (IPP) indicated client A's diagnosis included, but was not limited to, Disruptive Behavior Disorder.</p> <p>Client A's record indicated the client's Behavior Strategy was last revised on</p>				

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	<p>4/9/12. Client A's 4/9/12 behavior plan indicated client A demonstrated "inappropriate touching" and physical aggression. The behavior plan indicated "...[Client A's] explosive physical aggression has continued and appears to be driven by anxiety...The precursor is often when staff redirects him...Staff will continue to implement Mandt holds if needed to protect other residents, themselves, and/or [client A]." Client A's reactive strategies for physical aggression indicated the following:</p> <p>"1. If [client A] escalates into aggression (i.e. hitting, pulling hair, grabbing, or any other physical attack), one of the other staff should remove the other residents from the surrounding area, placing them in their rooms, the back hallway, outside, etc. and remain with them for their safety. This staff should also take the phone with them and call the on call person for assistance. A staff that [client A] has not focused on should talk to him with limited eye contact, speaking in a calm, matter-of-fact tone, stating, '[Client A], you need to calm down. Let's go talk about it.' A third staff should act as back up, closely monitoring the situation between [client A] and his staff. The second staff should stand back and closely watch what is transpiring, allowing [client A's] staff to try to calm</p>			
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	<p>him down, only intervening at the point that physical restraint through a MANDT technique is necessary...." The behavior plan indicated if client A continued to aggress, the back up person should assist client A's staff to implement a MANDT hold. The plan indicated the restraint holds should not last longer than 3 minutes and the client should be released if he dropped to the floor. Review of the client's 8/9/11 Behavior Strategy, in the client's record, indicated the client's behavior plan was the same as the 4/9/12 plan with only a few changes in wording. The 8/9/11 plan called for 3 staff as well in monitoring and/or utilizing the restraint techniques. The facility neglected to revise client A's 4/9/12 behavior program due to the client's increased aggression and unsuccessful restraint attempts to manage the client's aggression toward others.</p> <p>Client A's record indicated the facility had a behavioral specialist who worked for the facility. Client A's record indicated the behavior specialist documented behavioral information on client A's IDT Behavior Note and Quarterly Medication Plan reviews dated 6/12/12 and 3/29/12. The 6/12/12 review indicated the facility's Behavior Specialist (BS) documented client A demonstrated physical aggression toward</p>			
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	<p>staff 8 times in the past quarter and a total number of 5 restraints had been done for the quarterlies of March 2012, April 2012 and May 2012. The 6/12/12 report indicated the Behavior Specialist recommended the current behavior strategy be continued. The 6/12/12 note indicated "...[Client A] continues to have a difficult time in controlling his anxiety and aggression...." The note indicated client A had several medication changes within the quarter. Client A's 3/29/12 quarterly note indicated client A demonstrated 11 incidents of "physically attacking staff" for the quarters of 12/11, 1/12 and 2/12 with a total number of 7 restraints utilized. The 6/12/12 BS note indicated the client "had increased frequency of his physically aggressive behaviors." The note indicated client A's Behavior Strategy would be updated. Client A's 3/29/12 and/or 6/12/12 quarterly notes neglected to indicate when the behavior specialist went to the group home to monitor/observe client A as the notes indicated the BS only reviewed BIRs and IDT notes.</p> <p>Client A's record and review of the above mentioned IDT notes indicated the facility's administrative staff neglected to monitor/supervise the group home in regard to client A's physical aggression toward staff to ensure the client's</p>			

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	<p>behavior had not affected other clients, and/or neglected to ensure the administrative staff was actively involved to ensure a successful placement with client A, at the group home.</p> <p>Client C's record was reviewed on 8/24/12 at 9:48 AM. Client C's 8/25/11 IPP indicated client C was able to toilet himself, transfer himself and shower independently. Client C's 8/25/11 Behavior Strategy indicated the client demonstrated symptoms of depression. Client C's 8/25/11 IPP indicated the facility neglected to address/acknowledge how client A's aggression toward staff was affecting client C. Client C's 8/25/11 IPP, behavior plan and/or facility neglected to indicate how the facility would assist client C to feel safe/comfortable in his group home.</p> <p>Interview with the Program Coordinator (PC) and staff #1 on 8/15/12 at 4:05 PM indicated client A was visiting another group home. Staff #1 and the PC indicated client A had demonstrated verbal and physical aggression toward staff and would be verbally aggressive toward clients. The PC and staff #1 indicated client A's aggression had increased after the client's Trileptal was discontinued for medical reasons. The PC and staff #1 indicated facility staff</p>						

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	<p>would have to restrain client A when he became physically aggressive. Staff #1 and the PC indicated client A requires 2 staff to restrain the client. Staff #1 indicated there had been times when client A required more than 2 staff to be restrained. Staff #1 indicated the facility did not do floor restraints. Staff #1 stated client A would "try to intimidate staff, get in your face and be very angry." Staff #1 and the PC stated client A's behavior was "attention seeking." The PC and staff #1 indicated calling in outside staff used to work to deescalate client A when he became upset, but now was not working. Staff #1 and the PC indicated the group home only had female staff, but they had called over a couple of male staff from other group homes to work with client A. Staff #1 and the PC indicated client A's behavior improved for awhile but the client would still have behaviors when the male staff were around. The PC and staff #1 indicated the facility had increased staffing in the group home from 3 staff to 4 staff in July 2012 due to the client's behavior.</p> <p>Interview with administrative staff #1 on 8/17/12 at 10:40 AM indicated client A started having problems with increased aggression when the client was taken off his Trileptal due to low sodium levels. Administrative staff #1 stated "It was the</p>			

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	<p>beginning of the end." Administrative staff #1 indicated client A had been tried on different medications with no success. Administrative staff #1 indicated she was not aware of client A going after other clients in the group home as the client had aggressed against staff. Administrative staff stated, "He is clearly mentally ill." Administrative staff #1 stated the group home staff wanted a "quick fix and it is not happening." Administrative staff #1 indicated the group home staff felt client A could control his behavior more than he could. Administrative staff #1 indicated the management staff felt the group home staff wanted client A moved out of the group home. Administrative staff #1 indicated client A's incidents of aggression had decreased but the intensity had increased. Administrative staff #1 indicated the facility staff feels client A had learned some of the behavior as the client came from an abusive back ground. Administrative staff #1 indicated about 2 weeks ago, the management staff felt the client needed to go to another group home to visit to see if the environment at Cypress was some of the cause for the client's behavior. Administrative staff #1 stated "He can sense he is not wanted." Administrative staff #1 indicated client A was visiting at another group home for</p>			
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	<p>10 days as the client had recently completed a 3 day visit at the other group home. Administrative staff #1 indicated during the initial visit there were a few behaviors, but the client was doing fine now and not having any behaviors. Administrative staff #1 indicated client A would return to his group home on 8/20/12 after the day program to see if the client would do better and/or continue to have behaviors at the group home. Administrative staff #1 indicated if client A started to have behaviors when he returned to Cypress, the client would be moved to another group home. Administrative staff #1 indicated the administration was trying to figure out if it was the environment at Cypress and/or the client. Administrative staff #1 stated, "They (staff) think we are not responsive, but we are." Administrative staff #1 stated the group home staff were not "abusive or negative" with client A, but they did not agree with how the facility was handling client A. Administrative staff #1 indicated the facility was working with the group home manager and the PC to convey to staff the facility's expectations with client A. Administrative staff #1 "He is completely appropriate for a group home, Cypress and Rehabilitation Center." Administrative staff #1 indicated the psychiatrist just needed to find the right</p>			

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	<p>medication combination for the client. Administrative staff #1 stated "He is going to have behaviors. We have given him control." Administrative staff #1 stated, the staff were "frustrated" with the administration. Administrative staff #1 stated she had not been to the group home to speak to staff as administrative staff #1 did not want to "take away authority" from the manager and/or the PC of the home. Administrative staff #1 indicated the facility realized the manager was not conveying the same information to the staff on their expectations and thoughts with client A. Administrative staff #1 indicated the facility was currently working with the manager on this. When asked what had been done to change the staff's opinion/mind in regard to client A, administrative staff #1 indicated facility staff could have attended every IDT meeting but they did not. Administrative staff #1 indicated the manager had inserviced staff on the IDT meetings/changes and facility administrative staff had gone out to the group home to do observations with staff and their interactions with the clients. Administrative staff #1 stated "I don't think we waited too long, just cautious." Administrative staff #1 indicated she did not know if client A could be successful at the Cypress group home due to the</p>			
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	<p>way staff currently felt about the client. Administrative staff #1 stated client A's "behavior is not frequent, but when it occurs it is significant." Administrative staff #1 stated client A needed a "positive environment." Administrative staff #1 indicated client A may need to move to a different group home within the agency.</p> <p>Confidential interview H stated client A had been "very touchy and touching staff" since the client came back from visiting another group home. Confidential interview H indicated it would take 3 staff to restrain client A when he became upset. Confidential interview H indicated client A required 2 staff to do the restraint and 1 staff to watch/monitor. Confidential interview H indicated if client A started to bite staff, the third staff would need to assist in the restraint. Confidential interview H indicated client A had demonstrated physical aggression toward client B by pushing the client. Confidential interview H stated client A would "normally get in clients face and yell." Confidential interview H stated client C says "he is scared of him (client A). He will go back to his room and cry." Confidential interview H stated client E would sit in his room and say "What is wrong." Confidential interview stated "[Client G] whines and acts out due to</p>			

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	<p>what is going on." Confidential interview H indicated when client A became upset, 4 staff would not be enough to deal with client A's behavior. Confidential interview H stated client A would get "fixated on staff and the staff person would have to leave the house." Confidential interview H indicated administrative staff #2 had been out to the group home 2 times this month. Confidential interview H indicated administrative staff had not been coming out to the group home. When asked if the facility had a behavior specialist, confidential interview H stated "Yes." Confidential interview H indicated the BS had been out to the group home 3 to 4 times in the past year. Confidential interview H stated "Not frequent."</p> <p>Confidential interview I indicated client A would go after all the staff who worked when he had a behavior. Confidential interview I indicated she did not feel the facility was addressing client A's physical aggression toward the staff. Confidential interview I indicated 3 staff worked in the morning at the group home and the pager was called if client A had a behavior. Confidential interview I indicated client A would require 3 staff to perform a physical restraint. Two staff at the client's sides and one at the client's back to try and keep the client from</p>			
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	<p>dropping to the floor. Confidential interview I indicated facility staff would try to keep the other clients safe by placing the clients in their bedrooms and/or the medication room and closing the door. Confidential interview I stated "He is not a good fit for the home. More medically involved clients. He is not getting what he wants." Confidential interview I indicated the other clients in the group home would have to be left unattended when there were only 3 staff due to client A's behavior.</p> <p>Confidential interview J stated client A had a "rough year and a half." Confidential interview J stated "His behavior fluctuates from really awful to really good. We are all walking on egg shells to not set him off." Confidential interview J stated client A's behavior was "unpredictable." Confidential interview J indicated client A would get upset over anything. Confidential J stated "[Client A] was extremely aggressive toward everyone in house, mostly staff. He has moments of pushing and shoving clients." Confidential interview J indicated client A would get up in the clients' faces and yell at them. Confidential interview J stated client A's behavior "comes up so fast it is hard to redirect." Confidential interview J indicated client A used to calm down</p>				

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	<p>when someone from the outside came in and talked with the client. Confidential interview J indicated that did not work now. Confidential interview J indicated client A's behaviors could last up to 4 hours. Confidential interview J indicated the facility increased its staffing level to 4 staff on the evening shift a few months ago. Confidential interview J indicated when client A started having a behavior, 4 staff were not enough to deal with the client and to care for clients B, C, D, E, F, G and H. Confidential interview J indicated it would take 3 staff to restrain client A as one staff would be in back of client A and 2 staff would be on each side of the client. Confidential interview J stated "If 4 staff are here, it could take 4 staff to be in the immediate area. No one to watch other clients." Confidential interview J indicated the staff would have to call the emergency pager for assistance. Confidential interview J stated the Mandt holds they utilized were not always successful with client A as the client would drop to the floor and/or get out of the hold due to the client's "physical stature and flailing arms." Confidential interview J indicated during a behavioral incident, client H was left sitting in a wet adult diaper and client C was left sitting in a shower chair in the shower. Confidential interview J stated "It took all of us to deal with [client A]."</p>			
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	<p>When asked who monitored clients B, C, D, E, F, G and H when client A was having a behavior, confidential interview J stated "That is the problem." Confidential interview J stated client C was "scared and cries if behavior happens where he can see it." He told me [client A] scares him." Confidential interview J stated "[Client G] gets agitated. [Client F] fine until [client A] gets near him and he (client F) tenses up." Confidential interview J indicated client B had stolen food while client A was having a behavior. Confidential interview J stated client B was a "choking risk." Confidential interview J indicated client A would get upset with other clients during a behavior. Confidential interview J indicated client E would get angry and say something to client A and then client A would "react." Confidential interview J stated client J had "shoved him" (client E) on the shoulders before.</p> <p>Confidential interview K indicated client A required 2 to 3 staff when he needed to be restrained. Confidential interview K indicated client A's behavior had improved since he had been back from visiting another group home.</p> <p>Interview with staff #1, staff #2 and the PC on 8/24/12 at 10:40 AM indicated client A's visit to the other group home</p>			

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	<p>had gone well. The PC and staff #1 indicated client A's last medication change occurred on 8/9/12. Staff #1, #2 and the PC indicated the medication (Haldol) may be helping as the client had not had a behavior since he returned from his visit at another group home. Staff #1 indicated the facility was waiting to see how client A was going to do at Cypress before they made a decision on moving him to another group home. Staff #1 and the PC indicated the facility had done many program changes and medication changes in the last year. When asked if client A's behavior plan had been revised since 4/9/12, The PC indicated she thought it had been updated. The PC and staff #1 were not able to locate an updated plan. When asked how client A's 8/11 behavior plan for aggression was different from the 4/9/12 plan, the PC stated the "phrasing" was different and then stated " Not really different." When asked how many staff were required to do a restraint on client A, staff #1, #2 and the PC stated the client required 3 staff due to the "physicality of it. He is so much taller and his arm span is long." Staff #1 indicated client A would drop to the floor during a restraint. Staff #1 indicated a staff person would be on each side and one would stand at the back of client A to try and prevent the client from dropping to the floor as they</p>			

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	would have to release the client. Staff #1 and the PC indicated when the client would be released, client A would start to physically attack staff again or hit staff while in restraint due to his arm span. Staff #1 indicated she taught the Mandt restraint procedure for the agency. Staff #1 indicated she called the Mandt company and asked them what else could be done since the client was able to get out of the restraint by dropping to the floor. Staff #1 stated she was told by a Mandt official they needed to get taller people to do the restraint since the client was tall. Staff #1 and the PC indicated the facility did have male staff come and assist in the past. Staff #1 indicated client A would still drop to the floor with male staff, but he had done better with male staff historically. Staff #1, and #2 and the PC indicated 3 staff worked the morning shift and 4 staff worked in the evening. Staff #1 stated the staffing was increased in 7/12 to 4 in the evening as the morning shift was "not high risk" for client A. The PC indicated client A did have behaviors in the past on the morning shift, but the client was gone by 6:30 AM as the client went to the day service program earlier than the other clients. The PC indicated client A usually had behaviors in the evening after he came home from work so the staffing was increased on the evening shift. Staff			

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	<p>#1 and the PC indicated client A's behavior had affected the care the other clients received as the staff would have to attend to client A's behavior. When asked how the facility was assisting client C to feel comfortable/safe in his home, staff #1 and the PC indicated facility staff would reassure him it was ok. Staff #1, #2 and the PC indicated client C had made statements about being scared of client A. The PC indicated the client C's IDT had not met and/or formally addressed the concern. Staff #1 stated "[Client C] is more emotional than the others."</p> <p>Interview with the Behavior Specialist (BS) on 8/24/12 at 12:50 PM stated client A's physical aggression had been "ongoing for over a year." The BS indicated client A was being seen by a new psychiatrist as the other one moved out of state. The BS indicated the doctors had tried different behavioral medications to try and handle client A's aggression/behavior. The BS stated they are still looking for the "right combination." The BS stated the facility felt client A's aggression was due to an "environmental component." The BS stated facility staff had been inserviced on how to "address him." The BS stated client A would "continuously go after staff." The BS indicated the group</p>						

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	<p>home's staffing had been increased to 4 and the staff would call management staff who would go to assist. The BS stated the staff client A was "targeting" would go back and stay with the other clients while client A was having a behavior. The BS indicated she had not seen client A having a behavior. The BS stated when she would go out to the home, client A would be having a "good day." When asked how often the BS had been to the group home, the BS indicated she would see him at the day program and group home. The BS stated "it varies." The BS indicated she would see the client 2 to 4 times a month. The BS did not provide any documentation and/or dates she saw the client at the group home. The BS stated "[Name of doctor] thinks (client A's) behavior is due to abnormal brain activity." The BS indicated client A's behavior plan was last revised 4/9/12.</p> <p>Interview with administrative staff #2 on 8/24/12 at 1:45 PM indicated she was aware of the 7/28/12 and 7/31/12 incidents involving client A and other clients. Administrative staff #2 indicated it was not explained to her that the incidents were actual client to client incidents. Administrative staff #2 indicated the incidents did not need to be reported to state as there were no injuries</p>			

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	<p>with the incidents. Administrative staff #2 indicated the facility did not conduct an investigation in regard to the client to client incidents. Administrative staff #2 indicated the staff were Mandt certified and one to 2 person holds were used with client A. Administrative staff #2 indicated the facility staff were not able to hold client A in a restraint as the client would drop to the floor. Administrative staff #2 indicated the facility had called Mandt officials and they had told the facility they needed tall people to do the restraint. Administrative staff #2 indicated she was not aware of client C's concern with client A. Administrative staff #2 indicated if she was aware client C was fearful of client A, the facility would address it. Administrative staff #2 indicated client C did not say anything when she last saw the client.</p> <p>Administrative staff #2 indicated the facility was filling out a new 250 B physical form for the client to move to another group home. Administrative staff #2 indicated the facility was not quick to address the group home's staff's concerns in regard to client A's increased aggression toward the staff.</p> <p>Administrative staff #2 stated she had visited client A at the other group home and it "felt different" than when the client was at Cypress as the atmosphere was "tense." Administrative staff #2 stated</p>			
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	<p>the group home was "appropriate" for client A and client A was "paranoid" and thought others talked about him and did not like him. Administrative staff #2 indicated client A may need to move to a different group home. Administrative staff #2 stated administrative staff spoke with staff #1 and the PC about giving "positive support" in regard to client A. Administrative staff #2 stated "It took until now before we started to think we cannot ride this out (at Cypress)." Administrative staff #2 indicated client A's IDT will meet Monday (8/27/12). Administrative staff #2 indicated they wanted client A to return to Cypress after his visit at another group home, to see if it is the environment that is increasing his behavior. Administrative staff #2 indicated if the client continued to demonstrate aggression he would be removed to another group home for a 3 day visit until she could get BDDS (Bureau of Developmental Disabilities Services) to move the client on a permanent basis. Administrative staff #2 did not know how often the behavior specialist visited the group home.</p> <p>2. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 8/17/12 at 11:35 AM. The facility's reportable incident reports, internal incident reports</p>				

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	<p>and/or investigations indicated the following:</p> <p>-2/2/12 "While eating dinner yesterday evening, [client B] had finished his meal and his staff was standing right next to him instructing him to take his plate to the sink. As he stood to do so, he suddenly dropped his plate and grabbed another staff's food that she was eating directly on the table in from of him. [Client B] grabbed a large piece of her stromboli sandwich and began stuffing it in his mouth. This staff immediately intervened attempting to get the food out of his mouth. However, [client B] wants to eat the food and fights to keep you from getting it out, so he kept putting his hand up to his mouth and would push it back in. [Client B] then began choking as staff continued to try to get him to let them pull the sandwich back out. The Heimlich maneuver was done four times and [client B] did then cough up a large part of the sandwich (sic). [Client B] continued to cough a little more and then staff offered him a drink of water and he was okay afterwards. An immediate safety precaution for [client B] to begin eating in the den was implemented immediately until IDT could meet officially. [Client B] is a one-on-one when he eats and he is also a visual one-on-one in the main part of the house</p>						

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	<p>due to food stealing out of the cabinets and refrigerator. He has always been obsessive on food but seems particularly driven over the last several months. Numerous programming changes have been implemented; however, [client B] continues to find opportunities." The reportable incident report indicated the client's IDT met on 2/3/12 and decided client B would continue to eat separately from the other clients and staff. The reportable incident report indicated the staff, who was one on one with client B, would not eat when client B was eating in the den. The reportable incident report indicated client B was to be redirected to the back of the house once the client took his dishes to the kitchen and placed them into the sink.</p> <p>The facility's 2/9/12 follow-up report indicated "...[Client B] will also remain a visual one-on-one in the front part of the</p>			

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on 2 of 2 client to client allegations of abuse/incidents reviewed, the facility failed to conduct a thorough investigation in regard to the incidents of client to client aggression for clients A, B and E.</p> <p>Findings include:</p> <p>The facility's internal incident reports, reportable incident reports and/or investigations were reviewed on 8/17/12 at 8:35 AM. The facility's internal incident reports, reportables and/or investigations indicated the following:</p> <p>-7/31/12 "Another Resident (client B) had [client A's] pajama pants on. [Client A] walked up to the resident and chest shoved him." The 7/31/12 BIR did not indicate the facility had investigated the incident.</p> <p>-7/28/12 Client A had awakened from an afternoon nap when the client came into the kitchen and told staff to be quiet. The reportable incident report indicated "...Immediately after indicating for staff to be quiet, [Client A] came after staff pulling hair, hitting, kicking, biting, etc. Staff had to implement several MANDT</p>	W0154	<p>Administration met and reviewed clients A, B, and E's occurrences of client-to-client aggression. Administration reviewed and agreed our current policy is effective in this area. However, in this instance, staff in the group home failed to notify the on-call of the direct client-to-client occurrences. Therefore, all professional staff, as well as the direct support staff, will be retrained on their role related to client-to-client aggression. Additionally, administration developed a new protocol (See attached Client-to-Client Aggression Protocol) which outlines for the on-call person, as well as the group home coordinator, what information needs to be obtained and documented to ensure all occurrences of client-to-client aggression are investigated and reported per regulation.</p> <p>Systemically, all professional staff will be retrained on their roles related to client-to-client investigations. All professional staff will also be in-serviced on the new "Client-to-Client Aggression Protocol." Also, all direct care staff will be retrained in all homes to ensure any instances of client-to-client</p>	09/30/2012			

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	<p>holds, each lasting from one to three minutes. [Client A] was very upset and really no precursor was evidenced...Numerous people came in to assist in trying to calm [client A] down. The emergency on-call person came in, as well as the group home coordinator, and one of third shift staff. Generally another person coming in defuses the situation, but in these instances, it did not help...He was agitated and upset throughout the evening...."</p> <p>A second BIR on 7/28/12 at 6:45 PM indicated client A was attacking a staff person and went into another client F's bedroom. The BIR indicated when client F asked client A to leave his bedroom, client A "forcefully put his hand on [client F's] shoulder and yelled at him, yelling & (and) hitting staff in the head (sic)." The BIR indicated facility staff restrained the client 5 different times using a Mandt 2 person 1 arm standing restraint. The 7/28/12 reportable incident report and/or BIR did not indicate the facility conducted an investigation in regard to the client to client incident.</p> <p>Interview with administrative staff #2 on 8/24/12 at 1:45 PM indicated she was aware of the 7/28/12 and 7/31/12 incidents involving client A and other clients. Administrative staff #2 indicated</p>		<p>aggression is reported immediately to ensure swift investigation and reporting.</p> <p>In general, RCDS diligently works toward client-centered programming and implementation. As an agency moving forward, we feel that the implementation of the "Client-to-Client Aggression Protocol," will ensure client-to-client incidents are handled and investigated efficiently, while also ensuring swift implementation of client safety measures.</p> <p><u>CLIENT TO CLIENT AGGRESSION PROTOCOL</u></p> <p>To be completed by Group Home Coordinator after receive call from on-call Management</p> <p>-</p> <p>1. What staff on? What staff assignments? Were there enough staff?</p> <p>_____</p>		

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W0240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (C), the client's Individual Support Plan failed to indicate how facility staff were to assist the client to feel safe/comfortable in his home.</p> <p>Findings include:</p> <p>During the 8/24/12 observation period between 6:05 AM and 8:00 AM, at the group home, client C was placed at the counter across from client A to eat his breakfast. Client C hesitantly looked at client A while sitting across from the client at the kitchen counter. At 6:45 AM, clients A and C rode on the same van to go to their day programs/workshop. Client C's demeanor appeared flat and the client was not as talkative as he had been in the past. Confidential interview F indicated client A's aggressive behavior had been going on for over a year and a half. Confidential interview A indicated the facility had increased staffing at the home due to the client's behavior. Confidential interview A stated client C was "scared of [client A]" and would get upset when the client had a behavior.</p>	W0240	<p>IDT was monitoring the behavioral situation with Client A very closely, as the change in his behavior/mental illness was triggered by the discontinuation of the medication, Trileptal. The Trileptal was discontinued due to significant medical side effects, namely reduced sodium levels. IDT was meeting and discussing multiple programmatic changes; however, IDT felt the medication changes/adjustments through consultation with the psychiatrist were the crucial component in regaining stabilization for Client A, as he had been stable on the Trileptal for many years.</p> <p>IDT met numerous times to discuss Alan's aggression and explosive episodes. During those IDT meetings, we discussed Alan's individual program plan, behavior plan (specifically his proactive/reactive strategies and communication), medication adjustments/regulation with the psychiatrist, staffing, staff interventions, home visits with his family, environmental issues specific to the group home, day program issues at ASPIRE, staff training/interactions, staff program implementation, and observations that were being completed by the Behavior</p>	09/30/2012

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	<p>The facility's internal incident reports, reportable incident reports and/or investigations were reviewed on 8/17/12 at 8:35 AM. The facility's internal incident reports, reportables and/or investigations indicated the following (not all inclusive):</p> <p>-8/6/12 "[Client A] arrived home from day program and after putting away his belongings and toileting, he came into the kitchen to choose a snack. He chose strawberry cream cheese on crackers, which has to be softened per his diet orders. He did not want the food altered, nor did he want to wait...[Client A] became angry and began coming after staff. He pulled her hair, scratched, bit, spit, and tried pulling staff outside while telling them to 'get out.' Staff had to implement MANDT (physical restraint) restraints for their protection. Multiple holds were attempted, and they were successfully held for about 90 seconds...."</p> <p>-8/1/12 at 5:50 AM, the BIR indicated only 3 staff worked during the morning shift on 8/1/12. The BIR indicated "[Client A] was getting in another resident's face (client F) and attempting to touch him while eating. Staff calmly asked [client A] to let the other resident eat and to finish his juice so he could do</p>		<p>Coordinator and Director.</p> <p>Our agency currently operates with an effective abuse/neglect policy; however, it does not specifically address significant client behaviors resulting in abuse/neglect. The above areas that were addressed with Client A, are typical interventions for this type of situation and have been effective historically for us as an agency. However, due to state citations related to this particular situation, administration has developed a more specific behavioral response policy (See attached "Atypical Behaviors Intervention Policy") for potential futuristic behavioral situations. This policy will outline specific steps/interventions and will be utilized to ensure a methodical, specific policy is followed in all similar instances. The behavioral policy will ensure all necessary steps are discussed and implemented in a timely, successive manner.</p> <p>All professional staff will be trained on the new behavioral intervention policy. The Behavior Coordinator will be responsible for implementing the policy in all relevant meetings and ensuring all areas are covered and documented appropriately.</p> <p>Administrative staff worked closely with the group home coordinators, managers, and staff</p>				

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	<p>personal care and get dressed. [Client A] attacked staff after being asked to give the other resident space. He slapped staff, bit staff, punched staff and head butted staff. He went outside and banged on house windows, screamed and grabbed shears and threatened staff with them. He came back in and continued, hitting, biting and head butting staff. [Client A] grabbed staff and drug them into his bedroom trying to put staff on his bed. He punched his bed and furniture." The BIR indicated facility staff attempted to restrain the client 13 times "...but [client A] was too combative to be restrained..."</p> <p>-7/31/12 "Another Resident (client B) had [client A's] pajama pants on. [Client A] walked up to the resident and chest shoved him."</p> <p>-7/28/12 Client A had awakened from an afternoon nap when the client came into the kitchen and told staff to be quiet. The reportable incident report indicated "...Immediately after indicating for staff to be quiet, [Client A] came after staff pulling hair, hitting, kicking, biting, etc. Staff had to implement several MANDT holds, each lasting from one to three minutes. [Client A] was very upset and really no precursor was evidenced...Numerous people came in to assist in trying to calm [client A] down.</p>		<p>to ensure a successful placement transition for Client A. All of Client A's programming was reviewed, with numerous changes occurring with the behavior strategy to allow the client a new start, in a new environment, with new staff. Client A has recently transitioned to another group home operated by the Easter Seals Rehabilitation Center. Client A has done well in his new setting thus far, with no noted issues of aggression towards staff or other housemates. All of the new group home staff were trained on the updated programming with focus on positive interaction and moving forward in a positive manner.</p> <p>In general, RCDS diligently works toward client-centered programming. As an agency moving forward, we feel that the implementation of the "Atypical Behavioral Intervention Policy", will allow us to be more effective and efficient in handling client behavioral issues. The behavioral intervention policy will be utilized futuristically with Client A if a behavioral problem would arise. Preventatively and systemically, the policy will prevent future behavioral issues from evolving to this level, as the comprehensiveness of behavioral discussion areas, in combination with the consistency of meetings, will ensure successful</p>		

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	<p>The emergency on-call person came in, as well as the group home coordinator, and one of third shift staff. Generally another person coming in defuses the situation, but in these instances, it did not help...He was agitated and upset throughout the evening...."</p> <p>-7/17/12 "At dinnertime, [client A] did not want to set the table. He got up and walked toward the Group Home Manager in the kitchen. He grabbed for her hair and continued aggressively grabbing. Two other staff implemented a MANDT hold (for 1 minute) and he dropped to the ground out of the hold. [Client A] then tried to grab another staff. Staff placed him in another MANDT hold two more times for 45 seconds each...."</p> <p>-6/21/12 "[Client A] became agitated after arriving home from day program. He was coming back the hallway and staff was trying to turn on the light. He just came towards staff grabbing at their face and pulling hair. [Client A] went after all staff of (sic) shift and was seeking them out. He required approximately 10 MANDT restraints which were held for about one minute each as [client A] would drop to the ground requiring the hold to be released...."</p> <p>-6/16/12 "[Client A] was mocking another</p>		<p>intervention and/or other alternatives for placement being sought in a more timely manner.</p> <p><u>ATYPICAL BEHAVIORAL INTERVENTION POLICY</u></p> <p>1.An IDT will be held immediately when a significant behavioral change occurs related to any of the following areas:</p> <ol style="list-style-type: none"> Psychotropic medications change as a result of medical side effects Severe aggression towards staff or clients resulting in potential injury Client inability to be successfully maintained in a day program setting Excessive restraint in a short span of time <p>1.During the IDT, the Behavior Coordinator will facilitate discussion in the following areas and ensure all areas are discussed/addressed:</p> <ol style="list-style-type: none"> Identify problem/target behaviors Complete an immediate functional assessment if target behavior cannot be identified readily Evaluate current behavior in relation to current IPP/Behavioral programming and evaluate needed updates/changes Review current environmental impact (i.e. group home, day program home visits, 				

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	<p>resident (client E) & getting in their face. Staff tried to redirect [client A] asking him to out his socks on. [Client A] then attacked staff. [Client A] hit, pinched, pulled staff's hair, told staff to leave , hit told resident to leave, got in resident's face, tried dragging staff out of house, kicked staffstaff implemented 10 Mandt holds...Staff tried talking to [client A] to calm him down which was unsuccessful. Staff called pager. The BIR indicated only 2 staff were working in the group home at 6:15 AM when the incident occurred.</p> <p>-6/15/12 Client A hit staff in the arm and when it was explained he should not hit people, client A pulled staff's hair, bit staff, yelled, swung a blanket at staff, attempted to get a knife and hit staff with a box.</p> <p>-6/13/12 "[Client A] pulled staff's hair, slapped staff in the face, grabbed staff's clothing, punched staff, threw staff on the ground, pushed staff against the walls...spit in staff's face and slammed his fists down on tables and walls....Staff unsuccessfully attempted 13 MANDT holds. Staff successfully implemented 3 two person side body hug restraints...and 2 one person-two arm standing restraints..."</p>		<p>etc.) and</p> <p>evaluate for potential needed change</p> <p>e. Evaluate other housemates response to behavior (emotional distress, counseling, social skills training, etc.) and schedule individual IDT as warranted</p> <p>f. Review current staff impact (demeanor, interactions, program implementation, etc.) and evaluate potential necessary changes</p> <p>g. Evaluate staffs' emotional state (mental status, communication, counseling, through EAP, etc.)</p> <p>h. Review any potential medical issues/concerns and follow up with medical team</p> <p>i. Evaluate use of restraint (i.e. need, effectiveness, frequency, etc.). Consult with MANDT trainers as necessary</p> <p>j. Evaluate training/effectiveness of staff related to behavioral plan implementation and make changes as needed (i.e. retrain by behavior coordinator, model implementation by management, etc.)</p> <p>k. Consult with other professionals as necessary for outside input</p> <p>l. Ensure current placement is appropriate and review potential options for future</p>				

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	<p>-6/12/12 "[Client A] became aggressive with staff after they asked him to finish his juice. He was going at staff trying to hit, kick, bite, etc...Several restraints were required on order for [client A] to calm down...He continually goes after people when he is angry...."</p> <p>-6/8/12 Client A became upset with staff and started hitting and "physically attacked staff." The BIR indicated other clients were removed from the dining room to a "safe area" and the pager was called for assistance.</p> <p>-6/6/12 Client A punched and hit staff, bit staff and grabbed the staff's legs.</p> <p>-6/2/12 "[Client A] was getting settled in from his arrival home from day program. As he walked past a staff member, he hit her on the arm. Staff explained to [client A] that he should not hit others. [Client A] became upset and began pulling staff's hair, biting staff and himself, yelling, kicking, etc. Staff tried a variety of things to attempt to redirect [client A] and calm him down; however, he continued to be aggressive. Staff implemented several one-minute MANDT holds in order to assist [client A] to calm down.</p> <p>-5/23/12 When staff asked client A to come back into the dining room to finish</p>		<p>if necessary m. Evaluate program implementation/staff training routinely for continued efficiency and success</p> <p>3. Routine meetings (at least weekly) will occur to review all areas of concern and discuss progress and/or need for further changes. Meetings will be held more frequently if necessary.</p> <p>1.If behavioral problem cannot be effectively managed/resolved after above areas are addressed over a period if time, and the clients and/or staff remain at high risk, BDDS will be contacted for optional related to alternative placement. An IDT will be held in regard to Clients B, C, D, E, F, G, and H to discuss the potential effect that Client A's aggression has had on them. IDT will develop individual programming changes as needed for each client to ensure their health and well-being in case another situation such as this would arise again.</p> <p>Specifically with Client C, an IDT was held and IDT agreed that counseling would begin immediately and his IPP was updated to include social skills training related to assertiveness and communication. IDT feels</p>				

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	<p>his juice, "...[Client A] immediately became angry trying to smack staff, pulled hair, and spit on staff. [Client A] was very aggressive and coming after staff. Therefore, staff placed him in a MANDT hold (two person hold), per his behavior strategy...."</p> <p>-5/17/12 Client A hit staff in the arm and when staff told client A that he should not hit others, the client attacked staff and physically tried to punch the staff person out of the room.</p> <p>-4/27/12 Client A became upset when redirected to sit on toilet to let an enema work. The BIR indicated client A punched staff, spit in staff's face, bit staff on the head and arm and yelled at staff. The BIR indicated client A "forced staff outside the house" where he attacked staff again.</p> <p>Client C's record was reviewed on 8/24/12 at 9:48 AM. Client C's 8/25/11 Behavior Strategy indicated the client demonstrated symptoms of depression. Client C's 8/25/11 IPP indicated the facility did not address/acknowledge how client A's aggression toward staff was affecting client C. Client C's 8/25/11 IPP, behavior plan and/or facility did not indicate how the facility would assist client C to feel safe/comfortable in his</p>		<p>that the social skills training can focus on coping mechanisms and different scenarios, which will allow Client C to better understand and give him insight on how to handle this type of situation if it would arise again. This training will provide him with the knowledge and skill to hopefully feel more comfortable in his home environment or any other environment he may be in futuristically if a client would display aggressive behaviors.</p> <p>All direct care staff at Cypress will be retrained on the programming changes that have occurred for all clients. Additionally, staff will be retrained on their role in communicating behavioral issues as well as potential emotional effects that client behaviors may be having on other clients in the home.</p> <p>Systemically, all professional staff will be retrained on their roles in ensuring client behaviors are monitored closely. Also, retraining will include a focus on the other clients and the impact behaviors may be having on them emotionally as well. The IDT must meet as needed to ensure all client emotional well-being is monitored and addressed as necessary.</p> <p>In general, RCDS diligently works toward client-centered programming and</p>				

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	<p>group home.</p> <p>Confidential interview G stated when asked how the other clients felt about client A, confidential interview G stated "They seem intimidated to me when he has behaviors." The other clients are around watching. [Client C] goes back to his room. Staff gets everyone out of way or to the medication room and close the door to be safe."</p> <p>Confidential interview H stated client A would "normally get in clients face and yell." Confidential interview H stated client C says "he is scared of him (client A). He will go back to his room and cry."</p> <p>Confidential interview J stated client A had a "rough year and a half." Confidential interview J stated "His behavior fluctuates from really awful to really good. We are all walking on egg shells to not set him off." Confidential interview J stated client A's behavior was "unpredictable." Confidential interview J indicated client A would get upset over anything. Confidential J stated "[Client A] was extremely aggressive toward everyone in house, mostly staff. He has moments of pushing and shoving clients." Confidential interview J indicated client A would get up in the clients' faces and yell at them. Confidential interview J</p>		<p>implementation. As an agency moving forward, we feel that the implementation of the "Atypical Behavioral Intervention Policy", will allow us to be more effective and efficient in handling client behavioral issues. Preventatively and systemically, the intervention policy will address significant behavioral issues swiftly, and evaluate all areas routinely to ensure efficiency as well. This policy includes follow up related to other client's emotional well-being and ensures individual IDT's are conducted as necessary.</p>				

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	<p>indicated during a behavioral incident, client H was left sitting in a wet adult diaper and client C was left sitting in a shower chair in the shower. Confidential interview J stated "It took all of us to deal with [client A]." When asked who monitored clients B, C, D, E, F, G and H when client A was having a behavior, confidential interview J stated "That is the problem." Confidential interview J stated client C was "scared and cries if behavior happens where he can see it." He told me [client A] scares him."</p> <p>Interview with staff #1, staff #2 and the PC on 8/24/12 at 10:40 AM when asked how the facility was assisting client C to feel comfortable/safe in his home, staff #1 and the PC indicated facility staff would reassure him it was ok. Staff #1, #2 and the PC indicated client C had made statements about being scared of client A. The PC indicated the client C's IDT (interdisciplinary team) had not met and/or formally addressed the concern. Staff #1 stated "[Client C] is more emotional than the others."</p> <p>Interview with administrative staff #2 on 8/24/12 at 1:45 PM indicated she was not aware of client C's concern with client A. Administrative staff #2 indicated if she was aware client C was fearful of client A, the facility would address it.</p>						

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	<p>This federal tag relates to complaint #IN00113839.</p> <p>9-3-4(a)</p>			

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W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (B), the facility failed to implement the client's behavior plan in regard to food stealing.</p> <p>Findings include:</p> <p>During the 8/24/12 observation period between 6:05 AM and 8:00 AM, at the group home, client B had one to one staffing. A second staff (in training) was also with client B and his one on one staff person. At 6:21 AM, while client B was in the den area with the staff who was passing medication, staff #4, client B's one on one staff person, was in the kitchen with staff #5. Staff #4 told staff #5 client B was not allowed to prepare meals. Staff #4 was fixing client B's breakfast/plate. Staff #4 carried client B's plate to the den area where client B was located. At 6:44 AM, client B came out of the den/medication room. Client B was verbally prompted to sit at the kitchen counter. Staff #5 was standing</p>	W0249	<p>Staff have been trained on numerous occasions related to Client C's high risk choking plans/programming. This programming is encompassed in numerous documents including the dining plan, behavior plan, and individual program plan. IDT met and reviewed the current programs. IDT feels the current programs are effective; however, the implementation and understanding of the programming in this specific situation is of concern.</p> <p>Therefore, administration agreed that all staff will be retrained by the behavior coordinator on the details of Client C's high risk choking plans. Also, IDT agreed that Client C will begin being a full one-on-one staffing, as this will reduce staff's distraction to other clients and prevent potential mistakes with the implementation of Client C's programming.</p> <p>Disciplinary action ensued for the staff responsible for the incident sighted in the state plan of correction. The staff clearly understands, as do all the other</p>	09/30/2012			

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	<p>next to client B as staff #4 was in the kitchen preparing client B's lunch. Staff #4 then attempted to have client B help with preparing his sandwich. Client B grabbed the bread/sandwich and shoved half of it into his mouth and swallowed. Staff #5, who was standing next to client B, immediately grabbed the other half of the sandwich to keep client B from shoving the rest of the sandwich into his mouth. The food broke off into staff #5's hand. Client B attempted to grab and pry staff #5's hand open to try and get the food. Staff #4 then removed the bread from the counter and placed it back in the kitchen. Once client B saw he could not get the food, client B stood and walked into the den area and sat down on the couch.</p> <p>Interview with staff #4 on 8/24/12 at 7:55 AM when asked how client B got a hold of the bread/sandwich, staff #4 stated "I tried to have him assist in making lunch."</p> <p>Client B's record was reviewed on 8/24/12 at 10:03 AM. Client B's 11/29/11 Diet Plan indicated "[Client B] has a tendency to take others' food and ingest inedibles. [Client B] is a visual one on one when he is in the living room, med room, dining room, or kitchen due to his intense food stealing, resulting in a choking hazard...."</p>		<p>staff, that this client cannot be in the main area of the house when food preparation or clean-up is in process. Additionally, all staff, including management, are clearly aware that any future lack of follow through related to Client C's program implementation or one-on-one staff, will result in harsh disciplinary action up to termination due to the seriousness of the client's choking risk.</p> <p>The group home manager will also be retrained on her role to ensure that staff are following the programming diligently and correctly on a consistent basis. Preventatively, observations will be conducted five times per week for one month and then at least two times per week thereafter to ensure consistent implementation and maintaining of Client C's safety related to choking.</p> <p>All direct care staff at Cypress will be retrained on the programming changes related to Client C. They will also be made aware of the seriousness of his programming related to his choking and the ramifications if the programming is not adhered to.</p> <p>Systemically, all professional staff will be retrained on their roles in ensuring that programming is effective and also to ensure the programming is being</p>				

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	<p>Client B's 6/18/12 Behavior Strategy indicated client B had a Proactive Strategy for Taking Food From Others or the Kitchen Inappropriately. The strategy indicated "1. During all meals and snacks, [client B] will be staffed one-on-one within an arm's length until everyone is done eating and the kitchen and dining rooms are cleaned. 2. During snack and meal preparation, staff should involve [client B] in activities in his bedroom, the back area of the house, outside, or in the med room..." The 6/18/12 behavior plan indicated client B was not to assist and/or be around food that was being prepared.</p> <p>Interview with staff #1 and the Program Coordinator (PC) on 8/15/12 at 4:05 PM and on 8/24/12 at 10:44 AM indicated client B had a history of food stealing and choking. The PC indicated the Heimlich had been used with client B. Staff #1 and the PC indicated facility staff should not have client B assist in food/meal preparation.</p> <p>Interview with administrative staff #2 on 8/24/12 at 1:45 PM indicated client B was not to participate in food/meal preparation. Administrative staff #2 indicated client B was at risk for choking.</p>		<p>implemented consistently and effectively. In general, RCDS diligently works toward client-centered programming and implementation. As an agency moving forward, we feel that the implementation of the "Atypical Behavioral Intervention Policy" will allow us to be more effective and efficient in handling client behavioral issues. Preventatively and systemically, the intervention policy will address significant behavioral issues swiftly, and will include monitoring/observations of behavioral programming to ensure efficiency and success.</p>				

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