

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G367	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/16/2014
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NAME OF PROVIDER OR SUPPLIER  CARDINAL SERVICES INC OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1207 W WINONA AVE WARSAW, IN 46580
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: August 27 and 28, September 11 and 16, 2014.</p> <p>Facility Number: 000881 Provider Number: 15G367 AIMS Number: 100249180</p> <p>Surveyor: Amber Bloss, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/3/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview, the facility failed to implement written abuse/neglect policies and procedures to prevent neglect in regards for 1 of 1</p>	W000149	W149 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Per "Incident/Abuse/Neglect Policy	10/17/2014

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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	<p>BDDS (Bureau of Developmental Disabilities Services) report for an allegation of neglect for 2 of 4 sample clients (#2, #4).</p> <p>Based on record review and interview, the facility failed to implement written abuse/neglect policies and procedures to prevent client to client abuse for 3 of 3 BDDS reports reviewed for client to client abuse for 1 of 4 sampled clients (#1, #4) and 2 additional clients (#5, #6).</p> <p>Findings include:</p> <p>1) On 8/28/14 at 10:29 AM, the facility BDDS (Bureau of Development Disabilities Services) reports from 3/1/14 to 8/28/14 were reviewed. A BDDS report dated 7/9/14 indicated on 7/8/14 "at approximately 4:23 pm the on call manager received a call from staff stating that [Client #4] and [Client #2] were found sitting in the van. They had been on an outing previously with staff and a few other housemates. Upon returning home the 2 staff assisted 3 gentlemen into the home and [Client #4] and [Client #2] had been left in the vehicle." The report indicated "one staff assumed the other had assisted the individuals into the home; however, neither had resulting in these individuals being left unsupervised in the vehicle. Upon completing the</p>		<p>Persons Served" Cardinal Services, Inc. is committed to ensuring the safety, dignity, and protection of persons served. The support staff at the West Winona group home received additional training regarding this policy on 9/15/14 (see attachment A). Specifically, they were trained on following Client # 1's Community Involvement on 9/16/14. (See attachment B). Staff was further trained on Client # 1's amended Self-Management Plan on 9/17/14. (See attachment C). All staff in the Residential Program received additional training regarding the Incident/Abuse/Neglect Policy on 9/15/14. (See attachment A). Failure to follow will result in an incident report and disciplinary action as appropriate. Additionally vehicle safety training was sent to all Residential staff on 7/10/14. (See attachment D). To assure ongoing compliance and to ensure that this deficiency does not occur again the Residential Manager will monitor daily, QDP will monitor weekly and Coordinator will monitor quarterly. Coordinator, Manager and QDPs Responsible</p>				

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	<p>investigation it was found these individuals were left in the vehicle for approximately 1 hour and 20 minutes. The on call manager instructed staff to push fluids, check their vitals and report any concerns to the on call manager right away." The report indicated "the 2 staff responsible for this incident was (sic) suspended immediately pending an investigation. Upon concluding this investigation this incident was deemed as neglectful behavior and the 2 staff responsible has (sic) been terminated." The report indicated "additional training has been provided to all staff who was (sic) working in the home at the time of the incident in regards to active treatment as well as the incident/Abuse/Neglect policy."</p> <p>The investigation was reviewed on 8/28/14 at 10:29 AM and indicated "On July 8, 2014 [Client #4] and [Client #2] had returned from an outing with 2 staff and some of their peers. Upon returning staff failed to assist them into the home. Active treatment was not completed every 10-15 minutes which resulted in these individuals being unsupervised in the group home van for approximately 1 hour and 20 minutes." The investigation indicated "this is endangerment as the individuals were unattended and left in a vehicle without windows down." The</p>				

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	<p>investigation indicated the "conclusion" as "rights of persons served were violated as the health and safety of these individuals were jeopardized. These individuals did not receive active treatment every 10-15 minutes as written in their plans which resulted in these individuals being unsupervised which is against their Dr. (doctor) orders to have 24 hour care. This incident was deemed as neglect as the health and safety of [Client #4] and [Client #2] was jeopardized." The investigation outcome indicated "Both staff have been terminated per [facility] Abuse Neglect policy. All staff working in the home has (sic) received additional training in regards to active treatment. All staff working within the home who failed to provide supports to [Client #4] and [Client #2], which resulted in their health and safety being jeopardized, has (sic) also received disciplinary action per [facility] Employee Handbook."</p> <p>On 9/11/14 at 2:35 PM during an interview, the Residential Coordinator (RC) stated staff "were neglectful" by leaving clients #2 and #4 on the van unsupervised. The RC indicated it was against facility abuse and neglect policy to leave clients unattended.</p> <p>2) On 8/28/14 at 10:29 AM, the facility</p>			

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	<p>BDDS (Bureau of Development Disabilities Services) reports from 3/1/14 to 8/28/14 were reviewed. A BDDS report dated 3/12/14 indicated Client #6 was "sitting in a chair during dinner prep. [Client #1] was in the pantry and came out staring at [Client #6]. He began yelling and hitting and scratching at [Client #6] resulting in a 2 in (inch) scratch on his neck. Staff heard the yelling and attempted to get into the kitchen between [Client #6] and [Client #1] due to [Client #1] being agitated but was not able to get there in time. Staff immediately redirected [Client #1] to another area and checked to make sure that [Client #6] was okay." The BDDS report indicated "behavior plan followed." The report indicated "staff counseled [Client #1] to talk about what is upsetting him rather than hitting others." The report indicated "[Client #1] recently had a medication check up with his psychiatrist on 3/10/14 and had an increase in his Ativan (anti-anxiety) due to increasing obsessing behavior and agitation. [Client #1] does not normally hit other clients when he is upset but rather targets staff. IDT (interdisciplinary team) feels like this is an isolated incident and will continue to monitor to see if a pattern develops."</p> <p>A BDDS report dated 5/7/14 indicated</p>			
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	Client #1 "came back from the restroom and was standing in the dining room looking out the dining room window when he started yelling, 'shut up' and pointing (sic) this lasted roughly 2 minutes then he stopped yelling and began walking around the house for about 1 minute. He walked over to the dining room table and he began yelling and then he quickly walked over to [Client #4] and hit him twice on the back right upper side by his shoulder." The report indicated staff intervened "immediately blocking [Client #1] from hitting [Client #4] and [Client #4] was redirected from the area." The report indicated Client #1 "continued to attempt to go out any exit available to him to get outside. Staff blocked his attempts and once [Client #1] realized he was not able to exit through the garage he ran through the kitchen straight to the front door where staff intervened and reminded him to make good, safe choices." The report indicated Client #1 "hit staff in the face with his wallet. Before staff could redirect [Client #1], [Client #6] came around the corner from the hallway and [Client #1] ran towards [Client #6] hitting him in the upper left chest/shoulder area. Staff immediately placed [Client #1] in a [facility] approved hold per his HRC (human rights committee) approved Self-Management			

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	<p>plan. [Client #1] was in the hold for approximately 4 minutes before he calmed down and staff was able to release him from the hold." The report indicated Client #1 "has a follow up appointment with his Psychiatrist on Tuesday, May 13 (2014)...".</p> <p>A BDDS report dated 7/15/14 indicated "[Client #1] ran outside and started yelling and cursing. He calmed and stood there looking at the road and watching the traffic after a few minutes then went inside. He went and sat in front of the window. When he realize (sic) another staff had arrived he started to yell and curse and bang the walls, kicking everything he could. He went down the back hallway and continued to yell. He came out and went into the living room banging on the TV then to the kitchen. Staff was removing peers from the area when [Client #1] ran and kicked [Client #5]. [Client #1] started to hit and kick the staff that was blocking him from getting at [Client #5]." The report indicated "When other staff tried to redirect him to the living room he ran and kicked [Client #4] and staff. Staff got him redirected from the area and he was kicking and hitting staff (sic) the other staff took over and he started kicking and hitting them at that point staff was able to put [Client #1] in a</p>			

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	<p>[facility] approved support hold per his HRC Self-management plan for approximately 5 min. Once he stated that he was calm so she released him." The report indicated "he went and sat at the window to calm down then he got up and threw a chair. [Client #1] then finally calmed down. [Client #4] and [Client #5] did not sustain any injuries at this time. [Client #1] received a 1/2 inch scrape in his left wrist and 2 1/2 in scrape on his right leg from flipping over the chair."</p> <p>On 9/11/14 at 2:30 PM during an interview, the Residential Coordinator (RC) stated the BSP recommended by the Behaviorist "looked better" than the one developed by the facility. The RC stated she and the QIDP "dropped the ball" on including the Behaviorist's recommendations in Client #1's SMP. The RC stated she "agreed" Client #1's SMP should have been more thorough in providing staff with specific approaches to manage Client #1's behavior to prevent client to client abuse.</p> <p>On 9/11/14 at 3:25 PM the facility "Incident/Abuse/Neglect Policy" dated 5/13 indicated the facility "is committed to ensuring the safety, dignity, and protection of persons served. To ensure that physical, mental, sexual abuse,</p>			

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	neglect, or exploitation of persons served by staff members, or other persons served, or others will not be tolerated...".  9-3-2(a)			

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W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based on record review and interview, the facility QIDP (Qualified Intellectual Disabilities Professional) failed to integrate and coordinate revisions of a SMP (Self-Management Plan) to include recommendations made by the behaviorist, addendums made by the IDT (interdisciplinary team), and to include tracking of physical restraints for 1 of 4 sampled clients (#1).</p> <p>Findings include:  On 8/28/14 at 10:29 AM, the facility</p>	W000159	<p>W159 Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. The facility will ensure that active treatment programs are integrated, coordinated and monitored appropriately by qualified mental retardation professionals. QIDP's were trained to integrate and monitor programs on 9/19/14. (see attachment E) Client #1 Behavior Support Plan was updated on 9/12/2014. (see attachment C). Direct Support Professionals received training on the updated plan on 9/17/14.</p>	10/17/2014

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	<p>BDDS (Bureau of Development Disabilities Services) reports from 3/1/14 to 8/28/14 were reviewed. A BDDS report dated 3/12/14 indicated Client #6 was "sitting in a chair during dinner prep. [Client #1] was in the pantry and came out staring at [Client #6]. He began yelling and hitting and scratching at [Client #6] resulting in a 2 in (inch) scratch on his neck. Staff heard the yelling and attempted to get into the kitchen between [Client #6] and [Client #1] due to [Client #1] being agitated but was not able to get there in time. Staff immediately redirected [Client #1] to another area and checked to make sure that [Client #6] was okay." The BDDS report indicated "behavior plan followed." The report indicated "staff counseled [Client #1] to talk about what is upsetting him rather than hitting others." The report indicated "[Client #1] recently had a medication check up with his psychiatrist on 3/10/14 and had an increase in his Ativan (anti-anxiety) due to increasing obsessing behavior and agitation. [Client #1] does not normally hit other clients when he is upset but rather targets staff. IDT (interdisciplinary team) feels like this is an isolated incident and will continue to monitor to see if a pattern develops."</p> <p>A BDDS report dated 3/17/14 indicated</p>		(see attachment C) To ensure systemic compliance across the agency, all QIDP's received training to integrate, coordinate and monitor program plans on 9/19/14. (see attachment E) To ensure ongoing compliance, shift Managers will monitor each shift, Residential Manager will monitor daily, QDP will monitor weekly and Coordinator will monitor quarterly. Residential Manager, QIDP and Coordinator responsible.				

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	"[Client #1] was standing in the dining room looking out the window when he started yelling, hitting pictures on the wall, kicking the wall and swearing. Staff was in the room with [Client #1], following his HRC (human rights committee) approved Self-Management plan. Staff attempted to ask [Client #1] what was the matter however, he would not respond he just continued yelling and cussing." The report indicated "[Client #1] walked out of the dining room and into the living room still cussing. Staff followed him into the living room where he was hitting his picture on the wall. Staff intervened asking [Client #1] again why he was upset and blocked his attempts to hit the picture. [Client #1] walked towards the foyer where a peer was standing and attempted to hit his peer." The report indicated "staff immediately intervened placing [Client #1] in Cardinal Services (facility) support hold as outlined in his HRC approved Self-Management plan." The report indicated Client #1 "continued to to stomp on staff's feet and attempt to kick his foot back to kick staff however; he did quit yelling and cussing." The report indicated Client #1 "was in the hold for approximately 3 minutes until he calmed completely down and then he was released." The report indicated Client #1 sustained no injuries during the hold.			

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	<p>The report indicated Client #1 had an appointment with his psychiatrist on 3/18/14 for "follow up from toxic Depakote levels."</p> <p>A BDDS report dated 4/3/14 indicated "[Client #1] entered the kitchen where staff and peers were preparing lunch. [Client #1] requested juice and staff asked him to wait a second and they would help as it was about time to eat lunch. [Client #1] became upset when he was asked to wait and grabbed the staff member by the hair pulling her down and hitting her in the head and back with his fist. A second staff cleared [Client #1]'s peers from the area and placed [Client #1] in a Cardinal Services support hold as outlined in his HRC approved Self-management plan for the safety of those around him and himself." The report indicated Client #1 "was in the hold for approximately 5 minutes when he agreed to go to his room with staff and talk." The report indicated "[Client #1] was trained on coping skills that he can use when he comes upset instead of acting out negatively towards others." The report indicated Client #1 had a follow up appointment with his psychiatrist on 4/4/14.</p> <p>-An IDT (interdisciplinary team) note dated 4/3/14 indicated Client #1 "has</p>			
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	<p>been having more incidents of trying to go AWOL (absence without official leave), physical aggression towards staff and even peers, obsessing over money and going out, and just plain acting like he's miserable." The notes indicated Client #1 was waiting to move to a waiver living program. The team agreed Client #1 would be appropriate for waiver placement. The notes indicated staff would be retrained on Client #1's behavior plan.</p> <p>A BDDS report dated 4/23/14 indicated staff was standing outside with Client #1 when "without warning [Client #1] began kicking and hitting at the staff that was standing with him. The staff redirected [Client #1], blocking his attempts to hit and kick her. [Client #1] continued to cuss at the staff and began pulling her hair and hitting her in the face. A second staff intervened immediately placing [Client #1] in a Cardinal Services approved support hold per his HRC approved Self-Management plan." The report indicated Client #1 "continued to cuss and swing his arm for approximately 2 minutes before he calmed down." The report indicated Client #1 was released from the hold and spoke to his staff outside before returning to the house to call his mom. The report indicated Client #1 had a follow up appointment with his</p>			

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	<p>psychiatrist on 5/5/14.</p> <p>A BDDS report dated 4/27/14 indicated Client #1 "entered the living room where he observed another house member looking at magazines with pictures of houses, he immediately became agitated and tried to look at the magazine, staff intervened and put the magazines out of sight but [Client #1] became even more upset and started cussing at staff and kicking and hitting staff." The report indicated "when attempts to calm him down did not work and he went for staff's face he was put in an arm (hold) for approximately (sic) 2 minutes before he calmed down he was released from the hold (sic)...". The report indicated "no further concerns noted at this time. [Client #1] was trained on coping skills to use when upset instead of lashing out negatively at those around him."</p> <p>-An investigation dated 4/28/14 indicated the outcome: as "the peer received training on not taking items that did not belong to him. Once [Client #1] was calm after the incident staff reminded [Client #1] that when he becomes upset there are more appropriate ways to handle his frustration. He was given suggestions on listening to music, relaxing in his room, squeezing a stress ball, etc."</p>			
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	A BDDS report dated 5/3/14 indicated "[Client #1] was asked to give a peer some privacy, he stated, 'okay' and then walked away down the hall. Staff turned back around to assist one of [Client #1]'s peers when without warning [Client #1] came up behind staff, grabbed their hair and began hitting them in the head. A second staff came to assist and [Client #1], he cornered her and then began hitting and kicking at her. Staff phoned 911 due to [Client #1]'s violent behaviors as discussed by his IDT (interdisciplinary team) for his safety and the safety of those around him." The report indicated "another staff was able to get behind [Client #1] and get him to release the staff's hair he had cornered and place him in a [facility] approved support hold per his HRC (human rights committee) approved self-management plan. While in the support hold [Client #1] continued to stomp on staff's feet, cuss and yell. [Client #1] was in the hold for approximately 3 minutes when the officers arrived." The report indicated the "officers placed [Client #1] in handcuffs for his safety and the safety of those around him and transported [Client #1] to [hospital] for a medical clearance." The report indicated while at the hospital Client #1 "cussed at staff and became combative when the handcuffs were removed, attempting to hit, kick and bite			

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	<p>the Dr. and nursing staff." The report indicated Client #1 "was placed in soft hand and foot restraints for his safety and the safety of those around him." The report indicated Client #1 was given 2mg (milligrams) of Ativan (anti-anxiety) to calm him. The report indicated Client #1 was admitted to a psychiatric hospital for evaluation by his psychiatrist.</p> <p>A BDDS report dated 5/7/14 indicated Client #1 "came back from the restroom and was standing in the dining room looking out the dining room window when he started yelling, 'shut up' and pointing (sic) this lasted roughly 2 minutes then he stopped yelling and began walking around the house for about 1 minute. He walked over to the dining room table and he began yelling and then he quickly walked over to [Client #4] and hit him twice on the back right upper side by his shoulder." The report indicated staff intervened "immediately blocking [Client #1] from hitting [Client #4] and [Client #4] was redirected from the area." The report indicated Client #1 "continued to attempt to go out any exit available to him to get outside. Staff blocked his attempts and once [Client #1] realized he was not able to exit through the garage he ran through the kitchen straight to the front door where staff intervened and reminded him</p>			

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	<p>to make good, safe choices." The report indicated Client #1 "hit staff in the face with his wallet. Before staff could redirect [Client #1], [Client #6] came around the corner from the hallway and [Client #1] ran towards [Client #6] hitting him in the upper left chest/shoulder area. Staff immediately placed [Client #1] in a [facility] approved hold per his HRC (human rights committee) approved Self-Management plan. [Client #1] was in the hold for approximately 4 minutes before he calmed down and staff was able to release him from the hold." The report indicated Client #1 "has a follow up appointment with his Psychiatrist on Tuesday, May 13 (2014)...".</p> <p>A BDDS report dated 5/12/14 indicated Client #1 "walked through the kitchen into the living room and without warning began cussing, he took off his hat and then immediately grabbed [Client #4] by his shirt collar." The report indicated staff intervened and then Client #1 "walked to the backdoor to attempt to go AWOL (absent without official leave), staff again intervened and redirected [Client #1]." The report indicated Client #1 "started kicking at the door, tables and chairs while cussing at staff. [Client #1] kicked and hit at two different staff that was (sic) in the area. A third staff</p>			

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	<p>intervened placing [Client #1] in a [facility] approved support hold per his HRC (human rights committee) approved Self-management plan. [Client #1] was in the hold for approximately 1 minute before he calmed down and was released from the hold."</p> <p>-An investigation dated 5/13/14 indicated the outcome as "[Client #1] was reminded when he becomes upset that he needs to talk with someone rather than becoming angry and lashing out aggressively towards others. [Client #1] was interviewed by staff from the [waiver funded program] initiative and is awaiting the second phase in regards to moving into the waiver program." The investigation indicated "staff also received training in regards to getting [Client #1] involved more in his community so that he is spending less time in his home. A calendar was implemented for [Client #1] with scheduled outings throughout the day to assist with getting him move involved outside of his home."</p> <p>A BDDS report dated 6/4/14 indicated "staff was attempting to get [Client #1] to get his shower clothes. [Client #1] said no and began to walk towards the bathroom. Staff then followed him and got his shower tote out of the closet and</p>			

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	<p>turned to give it to [Client #1] when he started hitting the wall and biting his finger." The report indicated "he started toward the front door so staff followed him so that he would not go AWOL. At this time [Client #1] began to yell and cuss at the staff member and took his hat off and began hitting staff." The report indicated "staff blocked the hits and [Client #1] reached for and grabbed the staff's head. A second staff member stepped in and put [Client #1] in a [facility] approved support hold per his HRC (human rights committee) approved Self-management plan for approximately 4 minutes." The report indicated Client #1 "continued to kick and step on staff while yelling and cussing. The staff member that had [Client #1] in the hold was being pulled by him so the first staff member stepped in to trade spots. [Client #1] began to calm down after approximately 5 minutes and staff let go of one arm, at this time [Client #1] reached around and began hitting and kicking staff before the staff member could put his arm back in the hold." The report indicated "[Client #1] was placed back into the hold for approximately 5 minutes until he said he was okay. At this time he went to hug staff, as he normally does when he calms down, but he grabbed the staff member's hair and tried to hit staff's head on the wall.</p>			

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	<p>[Client #1] was once again placed into the approved hold for approximately 10 minutes until he was completely calm." The report indicated "staff will receive additional training on how to relieve training pressures when working with [Client #1]." The report indicated Client #1 "has a follow up appointment with his psychiatrist on June 10, 2014."</p> <p>-An investigation dated 6/4/14 indicated the conclusion as "it is the conclusion of the investigation that while staff did not give [Client #1] ample time when presenting him with training pressures. [Client #1] was becoming agitated at the time of the incident." The outcome indicated "a new training was implemented stating that when staff is working with [Client #1] and he is showing signs of agitation or he is asked a question and he responds with a no staff must STOP all training pressures with him IMMEDIATELY. Staff will need to give him space." The investigation outcome indicated "staff will need to provide supports to [Client #1] by asking him questions on what it is he'd like to do for example: [Client #1] would you like to take your shower now or in 5 minutes? Once he has responded then staff will need to follow his request."</p> <p>A BDDS report dated 6/19/14 indicated</p>			

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	<p>"staff heard banging and yelling coming from the upstairs bedroom area. When staff went to investigate they found one of [Client #1]'s housemates standing outside the office door with a pair of [Client #1]'s shoes on. Staff requested the shoes from the individual and then continued into [Client #1]'s room where the noise was coming from. [Client #1] took the shoes from staff's hands and hit staff in the face with one of the shoes." The report indicated "it was at this time that [Client #1] ran over to his window and started to hit it causing it to shatter." The report indicated staff was unable to intervene in time to prevent Client #1 from breaking the window. The report indicated Client #1 did not sustain any injury.</p> <p>A BDDS report dated 7/1/14 indicated Client #1 "went outside, as the QDP (qualified disabilities professional) was attempting to enter the house, he was kicking at the planters and yelling. The QDP stayed with [Client #1] trying to use verbal redirection to help calm him down. Every time that [Client #1] would go towards the door he would become more agitated." The report indicated Client #1 "became agitated hitting and kicking the Residential Manager. The QDP tried to intervene at that point [Client #1] began to target the QDP."</p>						

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	<p>The report indicated the Residential Manager "put [Client #1] into [facility] approved support hold per his HRC approved self-management plan for approximately 4 minutes."</p> <p>A BDDS report dated 7/4/14 indicated Client #1 "began yelling and cussing at staff and peers. He started hitting the table and the windows in the dining room while biting his finger. Staff tried to talk to [Client #1] to find out what was wrong and at approximately 3:45pm [Client #1] began to calm down and told staff he was sorry. 10 minutes later he began to yell and cuss again. At approximately 4pm [Client #1] went out the front door and while outside he was yelling and cussing; he was also kicking the railing around the front porch. After about 30 minutes [Client #1] came back inside. At 4:45 pm [Client #1] began to yell and cuss at his peers." The report indicated "staff intervened and while trying to redirect [Client #1], he grabbed the staff's face and started kicking the staff member. He then grabbed the back of the staff member's hair and was continuing to kick them. The staff member then guided [Client #1] to an area without anyone around. While staff was trying to find out what was wrong [Client #1] pushed the staff member into the entertainment center in the living room two times. At</p>			

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	<p>this time [Client #1] saw one of his housemates in another room and started toward them; he was shaking his fist and stating that he was going to punch his housemate. In order to prevent any injuries to [Client #1] or his peers staff at 5:15pm put [Client #1] in a [facility] approved support hold per his HRC (human rights committee) Self-management plan." The report indicated Client #1 was in the hold for approximately 10 minutes. The report indicated then [Client #1] began going upstairs when he saw the same housemate as previously stated and began to yell and cuss and kick the staff member and at that point staff put him back in the support hold for another 5 minutes..."</p> <p>-An investigation dated 7/3/14 indicated "it is the conclusion of this investigation that [Client #1] was just not having a good day at the time of the incident. There were no precursors to [Client #1]'s behavior." The "outcome" indicated "staff will continue to provide supports to [Client #1] and follow his HRC self-management plan."</p> <p>A BDDS report dated 7/8/14 indicated Client #1 "told staff he wanted to go out. Staff set his timer for him and reminded him that when the timer went off he</p>			

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	<p>would go out. [Client #1] became agitated and went out the front door, staff followed him out the door. [Client #1] started heading towards the road. Staff guided [Client #1] back into the home, however he continued to kick and hit staff. [Client #1] was placed in a support hold for approximately 2 minutes. [Client #1] seemed to have calmed down. [Client #1] went back towards the back bathroom of the home and began hitting and kicking the walls and doors. As staff were helping him calm him down, [Client #1] asked for a hug. [Client #1] then began to pull hair, kick and hit staff. He was then placed into another support hold for approximately 5 minutes." The report indicated "after [Client #1] was calm he was released from the approved support hold he resumed normal activities."</p> <p>-An investigation dated 7/7/14 indicated "it is the conclusion of this investigation that [Client #1] (sic) when he was not able to go out at the exact time that he wanted to. Staff followed all plans as written and this made [Client #1] upset causing him to become physically aggressive." The investigation "outcome" indicated "staff will continue to provide supports to [Client #1] and follow his HRC self-management plan. Staff will continue to offer [Client #1] activities to do to keep him engaged...".</p>			

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	<p>A BDDS report dated 7/15/14 indicated "[Client #1] ran outside and started yelling and cursing. He calmed and stood there looking at the road and watching the traffic after a few minutes then went inside. He went and sat in front of the window. When he realize (sic) another staff had arrived he started to yell and curse and bang the walls, kicking everything he could. He went down the back hallway and continued to yell. He came out and went into the living room banging on the TV then to the kitchen. Staff was removing peers from the area when [Client #1] ran and kicked [Client #5]. [Client #1] started to hit and kick the staff that was blocking him from getting at [Client #5]." The report indicated "When other staff tried to redirect him to the living room he ran and kicked [Client #4] and staff. Staff got him redirected from the area and he was kicking and hitting staff (sic) the other staff took over and he started kicking and hitting them at that point staff was able to put [Client #1] in a [facility] approved support hold per his HRC Self-management plan for approximately 5 min. Once he stated that he was calm so she released him." The report indicated "he went and sat at the window to calm down then he got up and threw a chair. [Client #1] then finally</p>			
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	<p>calmed down. [Client #4] and [Client #5] did not sustain any injuries at this time. [Client #1] received a 1/2 inch scrape in his left wrist and 2 1/2 in scrape on his right leg from flipping over the chair."</p> <p>-An investigation dated 7/14/14 indicated "it is the conclusion of the investigation that [Client #1] was upset because he wanted to see his mother. Staff has tried to contact his mother but have not been successful."</p> <p>Record review on 8/28/14 at 5:12 PM indicated Client #1's ISP (Individual Support Plan) dated 7/17/14 included a Self-Management Plan (SMP) dated July 2014. Client #1's SMP indicated his diagnoses included, but were not limited to, severe intellectual disabilities, psychotic disorder, Obsessive Compulsive Disorder, and Intermittent Explosive Disorder. Client #1's SMP indicated the targeted behavior of hallucinations, physical aggression, self-injurious behavior, elopement (AWOL), obsessiveness. Client #1's SMP indicated "Intervention Strategies" for physical aggression indicated the following:</p> <p>"Physical Aggression: I typically become physically aggressive because something</p>			

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	is not happening the way I want it to, whether it is me not getting what I want or one of my peers taking something from me. If staff pushes me too far I will begin to kick and punch at the staff member that is attempting to control my behavior. This is a good example to use to explain the proper intervention strategies for physically aggressive behavior. The first thing that staff needs to be aware of are the typical antecedent behaviors that I display before I become physically aggressive. If you are attempting to redirect me into the van, and I begin to look 'frustrated' and start biting my finger, it is a good sign for staff to relax some of the training pressures and give me room to calm down. If staff can be attuned to these antecedent behaviors it will help me deal with my feelings before they elevate into physically aggressive behaviors. If however I do become physically aggressive staff should always consider the safety of those around me, themselves and myself during the behavior. Staff should stay with me while giving me space, and if at all possible have other staff and peers leave the area to decrease the tension and give me some dignity and respect during my time of crisis. Staff should softly talk to me asking me what the problem is and how they can help, during this time if I continue to hit and			

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	<p>kick it is also important for staff to explain to me that this is not appropriate behavior and that it is not nice to hit your friends. While I am physically aggressive it is appropriate for staff to defensively block me from hitting and kicking them. My physical aggression is usually more of a communication than a desire to inflict pain. This can be done by using the side of your foot to block me from kicking you in the shins, make sure that you do this very carefully, so as not to trip me in the process. If I am hitting with my hands, it is appropriate to block the hits by simply catching my arms as I attempt to hit you, use an open palm to cup my forearm as I attempt to hit. It is very important to always be aware of your own safety, if you do not feel comfortable staying with me during this behavior or do not feel like you can adequately follow these guidelines, then ask another staff to step in and assist. Always use the least restrictive techniques first and follow [facility]'s self-management policy. If I become physically aggressive with a peer for doing something that upsets me, remove that peer from my presence and then follow the above discussed protocol for physically aggression. After I begin to calm down I will most likely be very sorry, and attempt to hug staff while crying. It is important that you let me</p>			
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	<p>know that it is 'ok' and that you still care about me. This is a great time to help me transition into something that I enjoy doing."</p> <p>Record review indicated "[Client #1] Notes" undated from the the Residential Coordinator (RD) which indicated the following:</p> <p>"2/10/14 - Behavior consultant finished working with [Client #1]. His plan did not reflect any changes in regards to the SMP (Self-Management Plan) that [Client #1] already had in place.</p> <p>3/10/14 - Psych (psychiatric) Review - Ativan (anti-anxiety) increased</p> <p>3/18/14- Psych Follow Up - Depakote (anti-convulsant) discontinued due to being elevated</p> <p>4/3/14 - IDT (interdisciplinary team) to discuss behavioral issues and discuss further strategies</p> <p>4/7/14 - Psych Review - Tegretol 200mg added at HS (bedtime)</p> <p>4/21/14 - My Life My Choice Interview (a waiver funded program)</p> <p>5/14/14 - Community Involvement -</p>			

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	<p>Implementation of [Client #1] going out 3 set times a day to provide him with a more structured activities outside of the home</p> <p>6/4/14 - Training provided to staff to release training pressure when [Client #1] is becoming upset</p> <p>6/10/14 - Psych Review - Ativan increased</p> <p>7/8/14 - Psych Review - Tegretol (anti-convulsant) was increased and his Ativan was decreased."</p> <p>Record review indicated a "Behavior Support Plan (BSP) and Functional Behavioral Assessment" developed by a Behavior Specialist dated 2/7/14 which was not implemented. The recommended BSP included the following elements (not all inclusive): "Replacement Behaviors and Operational Definitions - Guidelines for Teaching Functional and Useful Replacement Behaviors" which included "relaxation techniques" and "active engagement", "Proactive Intervention Methods to De-escalate and Reduce the Likelihood of Targeted Behaviors", "Reactive interventions to be used during occurrence of targeted behaviors (physical aggression and elopement), and "Crisis Prevention Institute De-escalation</p>			

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	<p>Techniques" which included "How to Respond Verbally" and "How to Respond Nonverbally". Client #1's recommended BSP included "Data Collection Instructions" which included "frequency count tracking forms, replacement behavior tracking, and ABC (a behavior tracking format which includes what happened prior to a behavior, during, and after) forms.</p> <p>Review of Client #1's SMP indicated the QIDP (Qualified Intellectual Disabilities Professional) failed to include recommendations made by a Behaviorist on 2/7/14. Review of Client #1's SMP indicated the QIDP failed to make an addendum to include the "Community Involvement" which was implemented on 5/14/14. Review of Client #1's SMP indicated the use of a "timer" for outings which was indicated in BDDS reports but was not included in Client #1's SMP.</p> <p>On 9/11/14 at 2:30 PM during an interview, the Residential Coordinator (RC) stated the BSP recommended by the Behaviorist "looked better" than the one developed by the facility. The RC stated she and the QIDP "dropped the ball" on including the Behaviorist's recommendations in Client #1's SMP. The RC indicated staff were trained on providing Client #1 with more</p>						

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W000289	<p>community outings (scheduled 3 times daily). The RC indicated Client #1's SMP was not amended to include the community outings as an approach to decrease targeted behaviors. The RC stated she "agreed" Client #1's SMP should have been more thorough in providing staff with more specific approaches to manage Client #1's behavior to prevent use of physical restraints.</p> <p>9-3-3(a)</p> <p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to</p>			

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	<p>manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.</p> <p>Based on interview and record review for 1 of 4 sampled clients (client #1), the facility failed to ensure systematic interventions in the Self Management Plan (SMP) were specifically written in the SMP.</p> <p>Findings include:</p> <p>On 8/28/14 at 10:29 AM, the facility BDDS (Bureau of Development Disabilities Services) reports from 3/1/14 to 8/28/14 were reviewed. A BDDS report dated 3/17/14 indicated "[Client #1] was standing in the dining room looking out the window when he started yelling, hitting pictures on the wall, kicking the wall and swearing. Staff was in the room with [Client #1], following his HRC (human rights committee) approved Self-Management plan. Staff attempted to ask [Client #1] what was the matter however, he would not respond he just continued yelling and cussing." The report indicated "[Client #1] walked out of the dining room and into the living room still cussing. Staff followed him into the living room where he was hitting his picture on the wall. Staff intervened asking [Client #1] again why he was</p>	W000289	<p>W289 They use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan. The facility will ensure that systematic interventions to manage inappropriate client behavior are incorporated into the client's individual program plan. QIDP's were trained to integrate systematic interventions into individual program plans on 9/19/14. (See attachment E). Client #1 Behavior Support Plan was updated to include tracking of systematic intervention on 9/12/14. (See attachment C). Direct Support Professionals received training on the updated plan on 9/17/14. (See attachment C) To ensure systemic compliance across the agency, all QIDP's received training to integrate systematic interventions into individual program plans on 9/19/14. (See attachment E) To ensure ongoing compliance, shift Managers will monitor documentation of systematic interventions on each shift, Residential Manager will monitor daily, QDP will monitor weekly and Coordinator will monitor quarterly. Residential Manager, QIDP and Coordinator responsible.</p>	10/17/2014			

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	<p>upset and blocked his attempts to hit the picture. [Client #1] walked towards the foyer where a peer was standing and attempted to hit his peer." The report indicated "staff immediately intervened placing [Client #1] in Cardinal Services (facility) support hold as outlined in his HRC approved Self-Management plan." The report indicated Client #1 "continued to to stomp on staff's feet and attempt to kick his foot back to kick staff however; he did quit yelling and cussing." The report indicated Client #1 "was in the hold for approximately 3 minutes until he calmed completely down and then he was released." The report indicated Client #1 sustained no injuries during the hold. The report indicated Client #1 had an appointment with his psychiatrist on 3/18/14 for "follow up from toxic Depakote levels."</p> <p>A BDDS report dated 4/3/14 indicated "[Client #1] entered the kitchen where staff and peers were preparing lunch. [Client #1] requested juice and staff asked him to wait a second and they would help as it was about time to eat lunch. [Client #1] became upset when he was asked to wait and grabbed the staff member by the hair pulling her down and hitting her in the head and back with his fist. A second staff cleared [Client #1]'s peers from the area and placed [Client</p>			

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	<p>#1] in a Cardinal Services support hold as outlined in his HRC approved Self-management plan for the safety of those around him and himself." The report indicated Client #1 "was in the hold for approximately 5 minutes when he agreed to go to his room with staff and talk." The report indicated "[Client #1] was trained on coping skills that he can use when he comes upset instead of acting out negatively towards others." The report indicated Client #1 had a follow up appointment with his psychiatrist on 4/4/14.</p> <p>A BDDS report dated 4/23/14 indicated staff was standing outside with Client #1 when "without warning [Client #1] began kicking and hitting at the staff that was standing with him. The staff redirected [Client #1], blocking his attempts to hit and kick her. [Client #1] continued to cuss at the staff and began pulling her hair and hitting her in the face. A second staff intervened immediately placing [Client #1] in a Cardinal Services approved support hold per his HRC approved Self-Management plan." The report indicated Client #1 "continued to cuss and swing his arm for approximately 2 minutes before he calmed down." The report indicated Client #1 was released from the hold and spoke to his staff outside before returning to the house to</p>			

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	<p>call his mom. The report indicated Client #1 had a follow up appointment with his psychiatrist on 5/5/14.</p> <p>A BDDS report dated 4/27/14 indicated Client #1 "entered the living room where he observed another house member looking at magazines with pictures of houses, he immediately became agitated and tried to look at the magazine, staff intervened and put the magazines out of sight but [Client #1] became even more upset and started cussing at staff and kicking and hitting staff." The report indicated "when attempts to calm him down did not work and he went for staff's face he was put in an arm (hold) for approximately (sic) 2 minutes before he calmed down he was released from the hold (sic)...". The report indicated "no further concerns noted at this time. [Client #1] was trained on coping skills to use when upset instead of lashing out negatively at those around him."</p> <p>A BDDS report dated 5/3/14 indicated "[Client #1] was asked to give a peer some privacy, he stated, 'okay' and then walked away down the hall. Staff turned back around to assist one of [Client #1]'s peers when without warning [Client #1] came up behind staff, grabbed their hair and began hitting them in the head. A second staff came to assist and [Client</p>						

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	#1], he cornered her and then began hitting and kicking at her. Staff phoned 911 due to [Client #1]'s violent behaviors as discussed by his IDT (interdisciplinary team) for his safety and the safety of those around him." The report indicated "another staff was able to get behind [Client #1] and get him to release the staff's hair he had cornered and place him in a [facility] approved support hold per his HRC (human rights committee) approved self-management plan. While in the support hold [Client #1] continued to stomp on staff's feet, cuss and yell. [Client #1] was in the hold for approximately 3 minutes when the officers arrived." The report indicated the "officers placed [Client #1] in handcuffs for his safety and the safety of those around him and transported [Client #1] to [hospital] for a medical clearance." The report indicated while at the hospital Client #1 "cussed at staff and became combative when the handcuffs were removed, attempting to hit, kick and bite the Dr. and nursing staff." The report indicated Client #1 "was placed in soft hand and foot restraints for his safety and the safety of those around him." The report indicated Client #1 was given 2mg (milligrams) of Ativan (anti-anxiety) to calm him. The report indicated Client #1 was admitted to a psychiatric hospital for evaluation by his psychiatrist.			

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	<p>A BDDS report dated 5/7/14 indicated Client #1 "came back from the restroom and was standing in the dining room looking out the dining room window when he started yelling, 'shut up' and pointing (sic) this lasted roughly 2 minutes then he stopped yelling and began walking around the house for about 1 minute. He walked over to the dining room table and he began yelling and then he quickly walked over to [Client #4] and hit him twice on the back right upper side by his shoulder." The report indicated staff intervened "immediately blocking [Client #1] from hitting [Client #4] and [Client #4] was redirected from the area." The report indicated Client #1 "continued to attempt to go out any exit available to him to get outside. Staff blocked his attempts and once [Client #1] realized he was not able to exit through the garage he ran through the kitchen straight to the front door where staff intervened and reminded him to make good, safe choices." The report indicated Client #1 "hit staff in the face with his wallet. Before staff could redirect [Client #1], [Client #6] came around the corner from the hallway and [Client #1] ran towards [Client #6] hitting him in the upper left chest/shoulder area. Staff immediately placed [Client #1] in a [facility] approved</p>			

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	<p>hold per his HRC (human rights committee) approved Self-Management plan. [Client #1] was in the hold for approximately 4 minutes before he calmed down and staff was able to release him from the hold." The report indicated Client #1 "has a follow up appointment with his Psychiatrist on Tuesday, May 13 (2014)...".</p> <p>A BDDS report dated 5/12/14 indicated Client #1 "walked through the kitchen into the living room and without warning began cussing, he took off his hat and then immediately grabbed [Client #4] by his shirt collar." The report indicated staff intervened and then Client #1 "walked to the backdoor to attempt to go AWOL (absent without official leave), staff again intervened and redirected [Client #1]." The report indicated Client #1 "started kicking at the door, tables and chairs while cussing at staff. [Client #1] kicked and hit at two different staff that was (sic) in the area. A third staff intervened placing [Client #1] in a [facility] approved support hold per his HRC (human rights committee) approved Self-management plan. [Client #1] was in the hold for approximately 1 minute before he calmed down and was released from the hold."</p> <p>A BDDS report dated 6/4/14 indicated</p>			

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	"staff was attempting to get [Client #1] to get his shower clothes. [Client #1] said no and began to walk towards the bathroom. Staff then followed him and got his shower tote out of the closet and turned to give it to [Client #1] when he started hitting the wall and biting his finger." The report indicated "he started toward the front door so staff followed him so that he would not go AWOL. At this time [Client #1] began to yell and cuss at the staff member and took his hat off and began hitting staff." The report indicated "staff blocked the hits and [Client #1] reached for and grabbed the staff's head. A second staff member stepped in and put [Client #1] in a [facility] approved support hold per his HRC (human rights committee) approved Self-management plan for approximately 4 minutes." The report indicated Client #1 "continued to kick and step on staff while yelling and cussing. The staff member that had [Client #1] in the hold was being pulled by him so the first staff member stepped in to trade spots. [Client #1] began to calm down after approximately 5 minutes and staff let go of one arm, at this time [Client #1] reached around and began hitting and kicking staff before the staff member could put his arm back in the hold." The report indicated "[Client #1] was placed back into the hold for approximately 5			

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	<p>minutes until he said he was okay. At this time he went to hug staff, as he normally does when he calms down, but he grabbed the staff member's hair and tried to hit staff's head on the wall. [Client #1] was once again placed into the approved hold for approximately 10 minutes until he was completely calm." The report indicated "staff will receive additional training on how to relieve training pressures when working with [Client #1]." The report indicated Client #1 "has a follow up appointment with his psychiatrist on June 10, 2014."</p> <p>A BDDS report dated 7/1/14 indicated Client #1 "went outside, as the QDP (qualified disabilities professional) was attempting to enter the house, he was kicking at the planters and yelling. The QDP stayed with [Client #1] trying to use verbal redirection to help calm him down. Every time that [Client #1] would go towards the door he would become more agitated." The report indicated Client #1 "became agitated hitting and kicking the Residential Manager. The QDP tried to intervene at that point [Client #1] began to target the QDP." The report indicated the Residential Manager "put [Client #1] into [facility] approved support hold per his HRC approved self-management plan for approximately 4 minutes."</p>			

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	<p>A BDDS report dated 7/4/14 indicated Client #1 "began yelling and cussing at staff and peers. He started hitting the table and the windows in the dining room while biting his finger. Staff tried to talk to [Client #1] to find out what was wrong and at approximately 3:45pm [Client #1] began to calm down and told staff he was sorry. 10 minutes later he began to yell and cuss again. At approximately 4pm [Client #1] went out the front door and while outside he was yelling and cussing; he was also kicking the railing around the front porch. After about 30 minutes [Client #1] came back inside. At 4:45 pm [Client #1] began to yell and cuss at his peers." The report indicated "staff intervened and while trying to redirect [Client #1], he grabbed the staff's face and started kicking the staff member. He then grabbed the back of the staff member's hair and was continuing to kick them. The staff member then guided [Client #1] to an area without anyone around. While staff was trying to find out what was wrong [Client #1] pushed the staff member into the entertainment center in the living room two times. At this time [Client #1] saw one of his housemates in another room and started toward them; he was shaking his fist and stating that he was going to punch his housemate. In order to prevent any</p>			
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	<p>injuries to [Client #1] or his peers staff at 5:15pm put [Client #1] in a [facility] approved support hold per his HRC (human rights committee) Self-management plan." The report indicated Client #1 was in the hold for approximately 10 minutes. The report indicated then [Client #1] began going upstairs when he saw the same housemate as previously stated and began to yell and cuss and kick the staff member and at that point staff put him back in the support hold for another 5 minutes...".</p> <p>A BDDS report dated 7/8/14 indicated Client #1 "told staff he wanted to go out. Staff set his timer for him and reminded him that when the timer went off he would go out. [Client #1] became agitated and went out the front door, staff followed him out the door. [Client #1] started heading towards the road. Staff guided [Client #1] back into the home, however he continued to kick and hit staff. [Client #1] was placed in a support hold for approximately 2 minutes. [Client #1] seemed to have calmed down. [Client #1] went back towards the back bathroom of the home and began hitting and kicking the walls and doors. As staff were helping him calm him down, [Client #1] asked for a hug. [Client #1] then began to pull hair, kick and hit staff. He</p>			

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	<p>was then placed into another support hold for approximately 5 minutes." The report indicated "after [Client #1] was calm he was released from the approved support hold he resumed normal activities."</p> <p>A BDDS report dated 7/15/14 indicated "[Client #1] ran outside and started yelling and cursing. He calmed and stood there looking at the road and watching the traffic after a few minutes then went inside. He went and sat in front of the window. When he realize (sic) another staff had arrived he started to yell and curse and bang the walls, kicking everything he could. He went down the back hallway and continued to yell. He came out and went into the living room banging on the TV then to the kitchen. Staff was removing peers from the area when [Client #1] ran and kicked [Client #5]. [Client #1] started to hit and kick the staff that was blocking him from getting at [Client #5]." The report indicated "When other staff tried to redirect him to the living room he ran and kicked [Client #4] and staff. Staff got him redirected from the area and he was kicking and hitting staff (sic) the other staff took over and he started kicking and hitting them at that point staff was able to put [Client #1] in a [facility] approved support hold per his HRC Self-management plan for</p>			

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	<p>approximately 5 min. Once he stated that he was calm so she released him." The report indicated "he went and sat at the window to calm down then he got up and threw a chair. [Client #1] then finally calmed down. [Client #4] and [Client #5] did not sustain any injuries at this time. [Client #1] received a 1/2 inch scrape in his left wrist and 2 1/2 in scrape on his right leg from flipping over the chair."</p> <p>Record review on 8/28/14 at 5:12 PM indicated Client #1's ISP (Individual Support Plan) dated 7/17/14 included a Self-Management Plan (SMP) dated July 2014. Client #1's SMP indicated his diagnoses, included but were not limited to, severe intellectual disabilities, psychotic disorder, Obsessive Compulsive Disorder, and Intermittent Explosive Disorder. Client #1's SMP indicated the targeted behavior of hallucinations, physical aggression, self-injurious behavior, elopement (AWOL), obsessiveness. Client #1's SMP indicated "Intervention Strategies" for physical aggression indicated the following:</p> <p>"Physical Aggression: I typically become physically aggressive because something is not happening the way I want it to, whether it is me not getting what I want</p>			

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	<p>or one of my peers taking something from me. If staff pushes me too far I will begin to kick and punch at the staff member that is attempting to control my behavior. This is a good example to use to explain the proper intervention strategies for physically aggressive behavior. The first thing that staff needs to be aware of are the typical antecedent behaviors that I display before I become physically aggressive. If you are attempting to redirect me into the van, and I begin to look 'frustrated' and start biting my finger, it is a good sign for staff to relax some of the training pressures and give me room to calm down. If staff can be attuned to these antecedent behaviors it will help me deal with my feelings before they elevate into physically aggressive behaviors. If however I do become physically aggressive staff should always consider the safety of those around me, themselves and myself during the behavior. Staff should stay with me while giving me space, and if at all possible have other staff and peers leave the area to decrease the tension and give me some dignity and respect during my time of crisis. Staff should softly talk to me asking me what the problem is and how they can help, during this time if I continue to hit and kick it is also important for staff to explain to me that this is not appropriate</p>			

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	<p>behavior and that it is not nice to hit your friends. While I am physically aggressive it is appropriate for staff to defensively block me from hitting and kicking them. My physical aggression is usually more of a communication than a desire to inflict pain. This can be done by using the side of your foot to block me from kicking you in the shins, make sure that you do this very carefully, so as not to trip me in the process. If I am hitting with my hands, it is appropriate to block the hits by simply catching my arms as I attempt to hit you, use an open palm to cup my forearm as I attempt to hit. It is very important to always be aware of your own safety, if you do not feel comfortable staying with me during this behavior or do not feel like you can adequately follow these guidelines, then ask another staff to step in and assist. Always use the least restrictive techniques first and follow [facility]'s self-management policy. If I become physically aggressive with a peer for doing something that upsets me, remove that peer from my presence and then follow the above discussed protocol for physically aggression. After I begin to calm down I will most likely be very sorry, and attempt to hug staff while crying. It is important that you let me know that it is 'ok' and that you still care about me. This is a great time to help me</p>			

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	<p>transition into something that I enjoy doing."</p> <p>Review of Client #1's SMP indicated the facility failed to ensure systematic interventions in the Self Management Plan (SMP) were specifically written to include facility approved support holds as indicated in the BDDS (Bureau of Developmental Disabilities Services) reports which indicated "holds" of Client #1.</p> <p>On 9/11/14 at 2:30 PM during an interview, the Residential Coordinator (RC) stated she "agreed" Client #1's SMP should have been more thorough in providing staff with more specific approaches to physical interventions and facility approved "support holds."</p> <p>9-3-5(a)</p>						
W000368	<p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based on record review and interview,</p>	W000368	<p><b>W368</b> The system for drug administration must assure that</p>	10/17/2014			

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	<p>the facility failed to assure drugs administered to 2 of 4 sampled clients (#1, #4) and 1 additional client (#5) were administered as ordered by the physician.</p> <p>Findings include:</p> <p>On 8/28/14 at 10:29 AM, the facility BDDS (Bureau of Development Disabilities Services) reports from 3/1/14 to 8/28/14 were reviewed and indicated the following reports:</p> <p>-BDDS report dated 3/30/14 indicated "staff was administering the 7:00 am medications when they discovered that [Client #1]'s 5:00 pm Ativan (anti-anxiety) 1mg (milligram) controlled substance log had not been signed on March 29, 2014. Upon further investigation it was observed that the Ativan 1mg had not been administered on the evening on March 29, 2014."</p> <p>-BDDS report dated 5/27/14 indicated "the on-call manager was notified that [Client #4] did not receive his 8:00 PM dose of Vimpat (anticonvulsant) 200 mg on May 25, 2014. The staff responsible for the error didn't realize she didn't administer the medication as nobody had checked 8:00 PM meds that night."</p> <p>-BDDS report dated 6/27/14 indicated</p>		<p>all drugs are administered in compliance with all physicians' orders. As an agency Cardinal Services strives to provide the best possible health care for the people that we support and to provide medication administration that is error free. To assure that staff follows each step of the medication pass staff in the West Winona group home received additional training regarding medication administration procedures on 10/10/14 (See attachment F) There have not been any additional medication errors in the West Winona group home since additional training was provided. To ensure that medication errors are reduced throughout the Residential Program, all Residential staff will receive additional training regarding medication administration by 10/16/14. To ensure this deficiency does not occur again, the Residential Manager, QDP, Nurse and Residential Coordinator will monitor the administration of medications through weekly, monthly and quarterly unannounced observations. Residential Manager, Nurse, QDP and Residential Coordinator Responsible.</p>				

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	<p>"while passing morning medications staff noticed that [Client #5] did not receive his last dose of Bactrim (antibiotic) on 6/26/14 at 7pm."</p> <p>-BDDS report dated 8/6/14 indicated "while passing 5 pm medications staff noticed that [Client #4] did not receive his Oyst.SH.CA (calcium supplement) 500/D, Carbamazepine (anticonvulsant) 100MG Chew (sic) and Carbamazepine 200MG on 8/3/14."</p> <p>-BDDS report dated 8/11/14 indicated Client #5 "had not received his dose of Dicto (sic) (stool softener) on Saturday, August 9 or on Sunday, August 10."</p> <p>-BDDS report dated 8/25/14 indicated "while passing the 7am medications it was found that [Client #4] did not receive his 7am dose of Vimpat (anticonvulsant) on 8/24/14."</p> <p>On 9/11/14 at 2:30 PM during an interview, the Residential Coordinator (RC) indicated all staff responsible for medication administration errors had been retrained. The RC indicated all staff should pass medications without error. The RC indicated medications should be administered as physician ordered.</p> <p>9-3-6(a)</p>			

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

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