

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G675	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2014
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NAME OF PROVIDER OR SUPPLIER PASSAGES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 990 E HANNA ST COLUMBIA CITY, IN 46725
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: February 3, 4, 6, 7, and 11, 2014.</p> <p>Facility Number: 009013 Provider Number: 15G675 AIMS Number: 100234550</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/18/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review, and interview for 3 of 3 sampled clients (clients #1, #2, and #4) and 1 additional client (client #6) who lived on side A of the group home, the facility failed to allow and encourage access to the</p>	W000125	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice?-The locked cover over the air temperature controls has been removed to allow and encourage access to the air temperature controls for</p>	03/13/2014

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>facility's locked air temperature controls for clients #1, #2, #4, and #6 and failed for 1 of 4 sampled clients (client #4) to ensure client #4 had a legally sanctioned representative to assist her with her medical and financial needs per her assessments.</p> <p>Findings include:</p> <p>1. On 2/7/14 at 11:25am, a record review for client #4 was conducted. Client #4's 5/14/13 "Informed Consent" assessment, 5/14/13 Individual Support Plan (ISP), and 5/14/13 BSP (Behavior Support Plan) indicated client #4 was not independent with her finances and/or medical care. Client #4's Informed Consent assessment, ISP, and BSP indicated the following areas were reviewed: personal finances, housing, personal safety, medical, behavioral, civil rights, and communication. The assessment, ISP, and BSP indicated client #4 required twenty-four hour supervision and assistance to understand to be able to give informed consent in each area. Client #4's 5/14/13 "Annual Update to Diagnostic Evaluation" indicated client #4 did not have a legally sanctioned representative and did not have a contact person outside the agency to assist client #4 to understand her rights. Client #4's record indicated she</p>		<p>clients #1, 2, 4, and 6.-Client #4 was referred to the Guardianship Council for a Guardian on 2-18-14. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?-Other air temperature controls in this home have been checked and do not have locked covers. Client #3, 5, 7, 8 have access to the air temperature controls. -Other clients assessed to be in need of a personal advocate or legally sanctioned surrogate decision maker will be referred for such assistance. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur. -All air temperature controls in all group homes have been checked and do not have locked covers over them. Should an individual be assessed and determined they are unable to have access to the air temperature controls, other individuals will maintain access by being provided a key to the locked cover. -Any new individual admitted to a Passages facility will be assessed to determine if they are in need of a personal advocate or legally sanctioned surrogate decision maker, and will be referred for such assistance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur?-During</p>				

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	<p>had been a victim of abuse in the past, was placed in the foster care system as an adolescent, was released from the foster care system and guardianship was terminated at eighteen years of age, and client #4 was admitted to the group home.</p> <p>On 2/11/14 at 11:55am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP stated client #4's Informed Consent assessment, ISP, and BSP did indicate she needed an advocate/guardian "to assist her with decision making process" for medications and with her finances. The QIDP indicated client #4 had been the victim of abuse in the past. The QIDP indicated client #4 did not have a legally sanctioned representative at this time. The QIDP indicated client #4 did not understand her rights, medications, or money and needed an advocate to assist to explain these to client #4.</p> <p>2. On 2/3/14 from 3:45pm until 5:45pm, and on 2/4/14 from 5:50am until 7:45am, clients #1, #2, #4, and #6 were observed on side A of the group home. The air temperature controls attached to the wall in the hallway near the living room had a locked cover. At 5:00pm, clients #1, #2, and #6 indicated</p>		<p>visits to the home, the QDDP will monitor that the clients are allowed and encouraged to exercise their rights. -Annually, the QDDP will assess each individual to determine if clients are in need of a personal advocate or legally sanctioned surrogate decision maker, and will be referred for such assistance.</p>				

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	<p>they did not have a key to their locked air temperature control. At 5:00pm, GHS (Group Home Staff) #2 indicated staff had the key and no client had keys to the locked air temperature control on side A of the group home. At 5:00pm, client #6 stated "I would ask for permission" to have the key from the staff. At 5:00pm, client #6 stated the air temperature control "was locked so we can't get to it."</p> <p>On 2/11/14 at 11:55am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated no client had an identified need for the locked air temperature control at the group home. The QIDP indicated no assessments were done to determine the need for locked air temperature controls for clients #1, #2, #4, and #6.</p> <p>On 2/7/14 at 12:20pm, a record review for client #1 was conducted. Client #1's 1/15/14 Individual Support Plan (ISP) and 1/15/14 FAT (Functional Assessment Tool) did not indicate client #1 had the identified need for locked air temperature control at the group home.</p> <p>On 2/7/14 at 1:40pm, a record review for client #2 was conducted. Client #2's 5/20/13 Individual Support Plan (ISP)</p>						

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W000225	<p>and 5/20/13 FAT (Functional Assessment Tool) did not indicate client #2 had the identified need for locked air temperature control at the group home.</p> <p>On 2/7/14 at 11:25am, a record review for client #4 was conducted. Client #4's 5/14/13 Individual Support Plan (ISP) and 5/14/13 FAT (Functional Assessment Tool) did not indicate client #4 had the identified need for locked air temperature control at the group home.</p> <p>9-3-2(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4), the facility failed to assess client #1, #2, #3, and #4's vocational needs, skills, work history, and work interests.</p> <p>Findings include:</p> <p>On 2/4/14 from 7:55am until 9:30am, at the facility's workshop clients #1, #2, #3, and #4 were observed in classrooms. At 8:20am, client #4 walked up/down the hallway holding the hand of a male client. At 8:30am, client #4 sat in the classroom without activity. At 8:30am,</p>	W000225	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice?The comprehensive functional assessment will be revised to include vocational needs, skills, work history, and work interests. Clients #1, 2, 3, 4 will be re-assessed with this new assessment tool. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Clients #5, 6, 8 of this home, and other clients who reside in SGL settings who attend Passages Creative Learning Center will be re-assessed with the revised</p>	03/13/2014

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	<p>client #4 refused to roll dice, participate in a game at the workshop, and sat without activity. At 8:45am, client #3 danced to music in the music classroom with facility staff. At 8:55am, clients #1 and #2 sat in the classroom without activity and staff made then custodially served coffee to clients.</p> <p>On 2/11/14 at 11:55am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated the workshop was responsible for client #1, #2, #3, and #4's assessments and development of their goals/objectives. The QIDP indicated client #1, #2, #3, and #4's assessments did not include their work history or work interests. The QIDP indicated clients #1, #2, #3, and #4 attended the previous workshop and had paid work by the piece until the workshop moved and no longer offered piece work. The QIDP indicated clients #3 and #4 had the opportunity to be considered for janitorial work at an hourly rate which the workshop assigned. The QIDP indicated no further vocational information.</p> <p>On 2/7/14 at 12:20pm, a record review for client #1 was conducted. Client #1's 1/15/14 Individual Support Plan (ISP) indicated a vocational goal/objective for</p>		<p>functional assessment tool which will include vocational needs, skills, work history, and work interests. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur. The revised vocational assessment will be used to assess clients who attend Passages Creative Learning Center annually or as needed.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur? The Passages QDDP will monitor to ensure other clients who reside in SGL settings who attend Passages Creative Learning Center are being assessed utilizing the revised vocational assessment annually or as needed.</p>				

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	<p>her not to boss others at day services. Client #1's ISP indicated "...Day Program, when given the option of retiring or semi retiring, [client #1] says no; she wants to continue attending daily; she likes the routine...She also participates in a senior program at the Creative Learning Center." Client #1's 3/18/13 "Vocational Assessment" did not indicate client #1's work skills. Client #1's vocational assessment did not include her work history or her work interests.</p> <p>On 2/7/14 at 1:40pm, a record review for client #2 was conducted. Client #2's 5/20/13 Individual Support Plan (ISP) indicated a vocational goal to engage in choice activity at day services and to return to her work area. Client #2's ISP indicated "...Work: [client #2] views her day program as another social opportunity. Although she knows the work procedures and rules and will participate in paid work at times, she is not highly motivated by money itself. She does enjoy getting a paycheck, but does not understand the relationship between working and receiving a pay check...." Client #2's 5/21/12 "Vocational Assessment" did not indicate client #2's work skills. Client #2's vocational assessment did not include her work history or her work</p>			

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	<p>interests.</p> <p>On 2/7/14 at 1:10pm, a record review for client #3 was conducted. Client #3's 9/6/13 Individual Support Plan (ISP) indicated a goal/objective to follow directions and to focus on the task presented. Client #3's 9/26/12 "Vocational Assessment" did not indicate client #3's work skills. Client #3's vocational assessment did not include her work history or her work interests.</p> <p>On 2/7/14 at 11:25am, a record review for client #4 was conducted. Client #4's 5/14/13 Individual Support Plan (ISP) indicated a vocational goal/objective to initiate work. Client #4's 5/14/13 "Vocational Assessment" did not indicate client #4's work skills. Client #4's vocational assessment did not include her work history or her work interests.</p> <p>9-3-4(a)</p>				

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W000249	<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 (client #4), the facility failed to ensure client #4's BSP (Behavior Support Plan) was implemented to secure knives when opportunities existed.</p> <p>Findings include:</p> <p>On 2/4/14 from 5:50am until 7:45am, clients #1, #2, #4, and #6 were observed at the group home on side A. During the observation period clients #1, #2, #4, and #6 assisted the facility staff with cooking, walked throughout the kitchen area, and client #4 opened and closed the drawers in the kitchen cabinets. From 5:50am until 6:45am, a five inch (5") knife was unsecured inside the kitchen silverware drawer on side A of the group home. At 6:45am, client #6 stated "That should not be there, Whew, I need to lock it up." Client #6 unlocked the sharps box and placed the five inch knife inside the box and relocked the locked knives. At 6:45am, Group Home</p>	W000249	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? Client #4's individual plan including the behavior support plan is being revised to allow client #4 access to the combination to the locked kitchen knives. The kitchen knives will continue to be locked in the lock box at this time. Staff will ensure that the knives are locked which supports the achievement of the objectives outlined in Client #4 individual plan. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All other clients residing in this home will receive an active treatment program that includes interventions and services to support the achievement of the objectives identified in their individual program plans. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur. Training will be provided to the staff in this</p>	03/13/2014			

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	<p>Staff (GHS) #1 stated clients #1 and #4 required locked knives for their safety and "everyone else's" safety at the group home.</p> <p>On 2/7/14 at 11:25am, a record review for client #4 was conducted. Client #4's 5/14/13 (Individual Support Plan) and 5/14/13 BSP (Behavior Support Plan) indicated client #4's behaviors included physical aggression, SIB (self injurious behaviors of cutting herself), and verbal aggression. Client #4's BSP indicated "...Intervention...Additional Restrictive Measures: 1. All knives are locked. [Client #4] used a kitchen knife to cut herself. She also pointed a knife at staff in a threatening way...."</p> <p>On 2/11/14 at 11:15am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated facility staff should have ensured that knives were kept secured and locked after each use. The QIDP indicated the unsecured knife should not have been inside the silverware drawer.</p> <p>9-3-4(a)</p>		<p>home regarding the implementation of the active treatment program including interventions and services to support the achievement of the objectives identified in the individual's program plans. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? During visits to the home, the QDDP will ensure that implementation of the active treatment program including interventions and services to support the achievement of the objectives identified in the individual's program plans is being completed.</p>		

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W000273	<p>483.450(a)(3) CONDUCT TOWARD CLIENT Clients must not discipline other clients, except as part of an organized system of self-government, as set forth in facility policy.</p> <p>Based on observation and interview, for 1 of 4 sampled clients (client #2) and 1 additional client (client #6), the facility failed to ensure client #6 did not implement client #2's training objectives and did not discipline client #2.</p> <p>Findings include:</p> <p>On 2/3/14 from 3:45pm until 5:45pm, observation and interviews were completed at the group home. From 4:45pm until 5:45pm, client #6 directed client #2 on how to wash her hands, how to carry a pitcher of fluids to the table, and how to sit in a chair in the living room to watch television without redirection of the facility staff. At 5:00pm, client #6 directed client #2 to go to the kitchen to put her green beans into a grinder with the group home staff without redirection. At 5:00pm, Group Home Staff (GHS) #4 redirected client #2 to grind oranges in the grinder. At 5:10pm, client #6 directed client #2 to rewash her hands without redirection of the group home staff. At 5:20pm, client #2 fed herself a bite of meat loaf and client #6 prompted client #2 to chew</p>	W000273	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? Clients will not discipline or implement client #2 training objectives. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Clients will not discipline or implement other clients training objectives. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur. Staff training will be provided to ensure that staff is implementing clients' training programs and that redirection is being provided should a client attempt to discipline or implement another client training program. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? During weekly visits to the home, the QDDP or Group Home Manager will monitor that other clients are not disciplining or implementing other clients' training programs, and that staff are providing redirection as needed. This monitoring will be documented on checklist that is kept at the group home.</p>	03/13/2014			

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	<p>with her mouth closed without redirection of the facility staff. At 5:20pm, client #2 closed her mouth to chew and client #6 stated "close more than that" without redirection of the facility staff. Client #2 then pressed her lips together when she chewed. At 5:20pm, client #6 then looked under the dining room table at client #2's feet. Client #2 had her feet entangled on the rails along the edges of her chair. Client #6 stated "put your feet on the stool" without redirection of the facility staff. Client #2 kept chewing her food and stared downward. Client #6 leaned over and reached out under the dining room table, grasped client #2's left and right legs by client #2's pant legs, and placed each of client #2's feet on the stool under the table without redirection by the facility staff. Client #2's head was downward as she chewed and consumed the rest of her meal.</p> <p>On 2/11/14 at 11:15am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated facility staff should have redirected client #6 from directing client #2's activities. The QIDP stated staff should direct clients for program implementation "not clients directing clients."</p>			

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W000289	<p>9-3-5(a)</p> <p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to 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. Based on record review and interview, for 2 of 2 sampled clients (clients #3 and #4) who had restrictive techniques employed, the facility failed to clearly define the specific techniques utilized in client #3 and #4's Behavior Support Plans (BSPs).</p> <p>Findings include:</p> <p>On 2/7/14 at 1:10pm, a record review for client #3 was conducted. Client #3's 9/6/13 Individual Support Plan (ISP) and 9/6/13 Behavior Support Plan (BSP) indicated client #3's targeted behaviors included physical aggression, verbal aggression, and gestural aggression. Client #3's BSP indicated "...Intervention...Guidelines for Teaching Functional Replacement Behaviors, Intervention Methods to Increase Prosocial Behaviors, and Decrease Maladaptive Behaviors...As staff interact with [client #3], CPI techniques used by staff trained in CPI (Crisis Prevention Intervention),</p>	W000289	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? Client #3 & 4 behavior support plans have been revised to include interventions to manage inappropriate client behavior including definitions of CPI techniques. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Other client's behavior support plans will be reviewed and revised to include interventions to manage inappropriate client behavior including definitions of CPI techniques. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur. The QDDP will ensure all interventions and definitions of CPI techniques are included in the individual's plans. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? The QDDP will review behavior support plans at least</p>	03/13/2014			

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	<p>requests to stop, and praise should be used in abundance...." Client #3's BSP did not specifically define which CPI physical restraints were to be used, failed to include when client #3 would require a CPI restraint, failed to indicate a written description of each approved hold, and failed to indicate the hierarchy from least restrictive to most intrusive techniques employed.</p> <p>On 2/7/14 at 11:25am, a record review for client #4 was conducted. Client #4's 5/14/13 (Individual Support Plan) and 5/14/13 BSP (Behavior Support Plan) indicated client #4's behaviors included physical aggression, SIB (self injurious behaviors of cutting herself), AWOL (Absent Without Leave), and verbal aggression. Client #4's BSP indicated "...Intervention...Crisis Prevention Institute (CPI) De escalation Principles and Techniques, Staff must be trained in CPI to use these techniques...." Client #4's BSP did not specifically define which CPI physical restraints were to be used, failed to indicate a written description of each approved hold, and failed to indicate the hierarchy from least restrictive to most intrusive techniques employed.</p> <p>On 2/11/14 at 11:15am, an interview with the QIDP (Qualified Intellectual</p>		<p>annually or when there is a revision in the plan to ensure that interventions to manage inappropriate client behavior including definitions of CPI techniques are included in their plans. Additionally, the Behavior Management Committee reviews client behavioral data monthly and makes recommendations for revisions in behavior support plans. The Human Rights Committee also reviews behavioral support plans quarterly.</p>				

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W000407	<p>Disabilities Professional) was conducted. The QIDP indicated facility staff had employed physical restraints on clients #3 and #4 over the year to control behaviors. The QIDP indicated clients #3 and #4 had physical restraints employed by the facility staff of: blocking restraints, a one person interim control hold restraints, and a two person full team control physical restraints. The QIDP indicated there was no documented evidence which described written interventions from least restrictive to most intrusive techniques staff were to employ for client #3 and #4's behaviors. The QIDP indicated client #3 and #4's BSPs did not state and/or define the specific techniques used for clients #3 and #4.</p> <p>9-3-5(a)</p> <p>483.470(a)(1) CLIENT LIVING ENVIRONMENT The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together. Based on observation, record review, and interview, for 1 additional client (client #7), the facility failed to ensure the group home environment met client #7's increasing behavioral needs.</p>	W000407	What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice?The Bureau of Developmental Disabilities Service Coordinator was notified of this potential deficiency on	03/13/2014

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	<p>Findings include:</p> <p>On 2/3/14 at 4:17pm, clients #5, #7, and #8 sat in the living room watching television on side B of the group home. At 4:17pm, client #7 got up from the sofa and began to walk fast towards client #5 who sat in a chair across the room. At 4:17pm, Group Home Staff (GHS) #6 positioned herself between clients #5 and #7 and redirected client #7 to an activity. From 4:17pm until 4:30pm, client #7 targeted clients #5 and #8 three additional times, swinging her arms, pointing at each client, and verbally yelling at clients #5 and #8. GHS #6 redirected client #7 to her bedroom. At 4:30pm, the QIDP (Qualified Intellectual Disabilities Professional) positioned herself between client #7 and clients #5 and #8. The QIDP redirected client #7 to her bedroom. From 3:45pm until 5:45pm, client #7 yelled, pointed at other clients, and made hand gestures of physical aggression toward clients #3, #5, and #8 on side B of the group home. At 3:45pm, GHS #7 indicated client #7 was on one on one staff supervision because of client #7's physical and verbal aggression.</p> <p>On 2/4/14 from 5:50am until 7:45am, observation and interview were</p>		<p>2-12-14. Client #7 was referred for alternative placement in November, 2013 due to ongoing aggressive behavior that was not able to be managed despite several inpatient psychiatric hospitalizations, medication changes, revisions in behavior support plan, involvement of a behavior consultant, and initiation of ECT. Client #7 was admitted to Generations Inpatient Unit on 2-14-14 due to increasing incidents and intensity of aggression. Client #7 has been accepted at Park Villa in Marion, Indiana and will be transferred to Park Villa from the Generations Inpatient Unit on 3-3-14. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?The Interdisciplinary team will complete an evaluation of Client #1, 2, 3, 4, 5, 6, and 8 which will take into consideration the needs, functional levels, ages, interests, social skills and abilities so that the health, safety, or development of other individuals is not impeded. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur.The Interdisciplinary Team at Passages will complete periodic assessments of individuals residing in the home, or who are being considered to reside in the home, which takes into</p>				

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	<p>conducted at the group home. From 5:50am until 6:12am, one staff, GHS #2, was present with clients #1, #2, #3, #4, #5, #6, #7, and #8. From 5:50am until 6:05am, clients #5 and #7 were alone on side B of the group home. From 5:50am until 6:05am, GHS #2 went back and forth from one side of the group home to the connecting opposite side of the group home. At 6:05am, GHS #2 administered client #7's medications in the medication room with the connecting doors of the group home closed. At 6:05am, GHS #8 arrived at the group home on side A. At 6:10am, client #7 exited the medication room into side B of the group home, client #2 entered the medication room, and GHS #2 closed the medication room doors. At 6:10am, GHS #2 indicated GHS #8 was on side A of the group home and not on side B with clients #5 and #7. From 6:10am until 6:18am, GHS #2 administered medication inside the medication room and no staff were present on side B of the group home. From 6:10am until 6:18am, client #7 yelled, screamed, hit the medication room door with her hands, and was verbally aggressive on side B of the group home. At 6:18am, GHS #2 indicated client #7 had a bond with her and preferred GHS #2 to be on side B of the group home. Client #7 quieted when</p>		<p>consideration the needs, functional levels, ages, interests, social skills and abilities so that the health, safety, or development of other individuals is not impeded. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? Passages QDDP will ensure that periodic assessments are completed of individuals residing in the home, or who are being considered to reside in the home which takes into consideration the needs, functional levels, ages, interests, social skills and abilities so that the health, safety, or development of other individuals is not impeded.</p>				

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	<p>GHS #2 exited the medication room and entered side B of the group home.</p> <p>Client #7's record was reviewed on 2/7/14 at 2:15pm. Client #7's 11/26/13 BSP (Behavior Support Plan) indicated she had targeted behaviors of physical aggression, verbal aggression, and uncooperative behavior. Client #7's BSP indicated "1. Verbal Aggression/Agitation: Definition of verbal aggression/agitation: verbal outbursts, verbal attacks directed at others in the form of yelling, threatening, glaring, or pointing her finger. 2. Physical Aggression: Definition of physical aggression: hitting, pushing, throwing objects, or any physical contact with the intent of harming." Client #7's BSP indicated client #7 "has been given psychiatric diagnoses of Schizophrenia, Organic Personality Disorder Explosive, and Intermittent Explosive Disorder" and indicated the use of ECT (Electroconvulsive Therapy, A procedure in which a brief application of electric current to the brain, through the scalp induces a seizure. It is typically used to treat a patient who is suffering from severe depression).</p> <p>On 2/7/14 at 2:15pm, Client #7's undated "History" of behaviors</p>			

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	<p>documented by the QIDP (Qualified Intellectual Disabilities Professional) which included outside services interventions indicated the following:</p> <p>-On 2/7/14, the "group home manager received call from the ECT Scheduling department. [Client #7] is scheduled for ECT on 2/17/14, 2/26/14, 3/5/14, and 3/12/14."</p> <p>-On 2/6/14, "We had not received a call from the scheduling department for ECT yet [QIDP] left message for the ECT nurse regarding this."</p> <p>-On 2/4/14, "Contacted Psychiatric Care about recommendations for ECT treatments. The Recommendation was that [Client #7] be scheduled for weekly ECT treatments for the next four weeks. The scheduling department will call to arrange for treatments."</p> <p>-On 1/31/14, "Contacted Psychiatric Care Center's ECT nurse. Gave update on [Client # 7's] behavior and that her aggression has increased to up to 10 incidents on some days. She will let the nurse practitioner knows (sic) and will call back for ECT schedule."</p> <p>-On 1/31/14, "Contacted [BDDS</p>			

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	<p>representative] at BDDS to follow up on placement referral. She has not heard anything from [Level of Care Assessor]. She will let him know we are still awaiting next steps (for) information regarding [Client #'s] relocation."</p> <p>-On 1/24/14, "Update given to Psychiatric Care Center with increased aggression noted after the last ECT treatment. Information will be forwarded to the nurse practitioner. No treatment ordered for the upcoming week."</p> <p>-On 1/21/14, Client #7 "had an ECT treatment today. Consent was obtained from her parents/guardians. Weekly updates will be given to determine the frequency of the ECT treatments from this point forward."</p> <p>-On 1/14/14, an "E-mail sent to BDDS (Bureau of Developmental Disabilities Services), to inquire as to whether (BDDS) has received any more information on [Client #'s] referral (for level of care determination). [BDDS representative] replied that she has not heard anything new."</p> <p>-On 1/9/14, Client #7 "was scheduled for an ECT treatment on 1-10-14. The ECT clinic called and indicated that</p>						

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	<p>their consent for treatment has expired and that they could not reach [Client #7's] guardians. The ECT clinic was notified that her guardians are on a cruise and will return on 1/18/14. They are unable to provide any further treatments until this consent is signed. [Client #7] had an appointment with Psychiatric Care today. Discussion was held about the ECT. They will schedule [Client #7] for a treatment on January 21st. Reported [Client #7's] increased tremors which at times make it difficult for [Client #7] to ambulate. They recommended she have a PT evaluation for possible use of an assistive device. They also ordered Clonazepam (medication) for her tremors."</p> <p>-On 12/19/13, the agency QIDP "notified BDDS that [QIDP] received a call from a family member who expressed concern about [Client #7] hitting her daughter."</p> <p>-On 12/12/13, the QIDP received notification from BDDS representative "in an e-mail from [BDDS which] indicated that [Level of Care] recommended an ESN or [Large behavioral facility placement]."</p> <p>-On 11/26/13, "[Client #7's] ISP meeting held. [Client #7's] parents/guardians</p>			

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	<p>attended via phone conference. They were agreeable to the plan that was developed for [Client #7] including her self management plan which includes the use of psychotropic medications and ECT. Plan will be sent to them for signature. After the meeting [QIDP] met with [BDDS representative] to talk about alternative placements, and to provide additional information for referrals to specific locations."</p> <p>-On 11/17/13, "Nighttime incontinence improved. Staff is able to awaken [Client #7] to toilet during the night."</p> <p>-On 11/12/13, "Urinalysis completed. UTI (Urinary Tract Infection) present and started on anti-biotic."</p> <p>-On 11/11/13, "Call in to Psychiatric Care due to extreme lethargy during the night and bedtime incontinence. No call back received."</p> <p>-On 11/10/13, "Call in to Psychiatric Care due to extreme lethargy during the night and bedtime incontinence. No call back received."</p> <p>-On 11/7/13, "Seen by Behavior Consultant."</p>			

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	<p>-On 11/4/13, "Follow up appointment with [Psychiatric Physician]. Due to continued physical aggression, Clozaril 25mg. (milligrams) at noon added."</p> <p>-On 10/28/13, "[Client #7] returned to Passages. Medications include Clozaril 25 mg. AM and 200 mg. at bedtime. Trazodone 100 mg. at HS (at bedtime for behaviors)."</p> <p>-On 10/9/13, "[Client #7] physically aggressive toward peers and staff. One to one staffing initiated overnight. Contacted Psychiatric care and left message. Contacted [Name of Inpatient Psychiatric Hospital] for admission to inpatient unit. [Client #7] admitted to unit [Name of Doctor] recommended an alternative placement be sought for [Client #7]. BDDS notified."</p> <p>-On 10/8/13, "Call in to Psychiatric Care. Phone nurse stated they were calling [Client #7's] neurologist as the Clozaril may interact with her seizure medication. Explained that [Client #7] continues to demonstrate physical aggression toward her peers and staff. Asked if an inpatient stay would be considered to draw baseline labs and initiate the Clozaril while she is inpatient. [Psychiatrist Name] was contacted and he did not want to admit</p>						

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	<p>her at this time."</p> <p>-On 10/7/13, "Call in to Psychiatric Care as no orders received."</p> <p>-On 10/4/13, "Seen at Psychiatric Care. No changes in medication. [Behavioral Center] suggested trying Clozaril. [Behavior Center] explained the lab protocol. This was discussed with her parents, and they were in agreement. [Behavioral Center] to call with orders for baseline lab tests."</p> <p>-On 9/20/13, Client #7 was "Taken to Psychiatric Care for appointment. [Client #7] was unable to be seen as Parents/Guardians refused to sign consent. Discussed with parents they are not responsible for the payment from these appointments as their guardianship only covers the person not the estate."</p> <p>-On 8/13/13, Client #7 "Returned to Passages. Seroquel XR 100mg. 8 AM and 3 PM, Seroquel 600 mg. at bedtime (for behaviors). Follow up ...at Psychiatric Care on 9/20/13."</p> <p>-On 7/31/13, Client #7 "Admitted to [Name of Inpatient Psychiatric Hospital] due to continued physical aggression. ECT initiated on 8/5/13."</p>			

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	<p>-On 7/29/13, Client #7's "Bedtime dose of Seroquel increased to 500mg."</p> <p>-On 7/8/13, Client #7's "Bedtime dose of Seroquel increased to 400mg."</p> <p>-On 6/25/13, Client #7 "Admitted to [Name of Inpatient Psychiatric Hospital]. (6-25-13 through 7-5-13). Geodon discontinued. Seroquel 150 mg. 9 AM, 3 PM and Seroquel 250 mg. Bedtime. Follow up with Psychiatric Care Center on 8-8-13."</p> <p>-On 6/20/13, "[Name of Doctor] increased Seroquel to 100mg. TID (three times a day)."</p> <p>-On 6/19/13, Client #7 had "Appointment with neurologist. Tegretol reduced to 200mg. TID. Follow up in 2 mos.(months)."</p> <p>-On 6/17/13, Client #7 "Struck several clients at day program. [Name of Psychiatric Center]contacted, instructed that medical concerns need to be ruled out first. Contacted [Name of Doctor] and he ordered CBC, CMP, and Urinalysis. Urinalysis shows bacteria in urine, and [Name of Doctor] notified. Anti-biotic initiated. Spoke with [Name of Doctor]. He recommended follow up</p>			

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	<p>with the neurologist and ask if Tegretol is causing any interaction with the Seroquel or Geodon. Consider Trileptal? Follow up with [Name of Doctor] on 6/20/13."</p> <p>-On 6/15/13, Client #7 "Pushed housemate off of chair at home."</p> <p>-On 6/12/13, "Received order to change Tegretol to 300 mg. at AM, 300 mg. 3 PM, and 200 mg. at bedtime. Call back in one week if no change in behavior."</p> <p>-On 6/7/13, "Obtained order to check Tegretol level."</p> <p>-On 6/3/13, Client #7 had "Aggressive behavior started. Pointing, yelling, and attempting to strike out at staff and peers."</p> <p>-On 5/30/13, "Seen (sic) [Name of Doctor] at [name of psychiatric center], no changes made."</p> <p>-On 5/28/13, Client #7 "Returned to Passages, Inc."</p> <p>-On 5/15/13, Client #7's "Tegretol (for behaviors) increased to 400 mg. BID (twice daily)."</p> <p>-On 4/26/13, Client #7 was "Transferred</p>			

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NAME OF PROVIDER OR SUPPLIER PASSAGES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 990 E HANNA ST COLUMBIA CITY, IN 46725
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	<p>back to [Name of Nursing Home]. Seroquel (for behaviors) and Geodon (for behaviors) continued. Tegretol titrated due to seizures."</p> <p>-On 4/20/13, Client #7 was "Transferred back to [Name of Inpatient Psychiatric Hospital] at [Name of Hospital]. Started on Seroquel, and Geodon continued. Behavior stabilized."</p> <p>-On 4/15/13, "Transferred to [a local Nursing Home]. [Client #7] was very combative."</p> <p>-On 4/7/13, "Transferred to [Name of Hospital] ICU (Intensive Care Unit) due to Aspiration Pneumonia."</p> <p>-On 4/3/13, Client #7 was "Taken to [Name of Hospital Emergency Room] per [Name of Doctor] due to inability to walk and eat. Transferred to [Name of Inpatient Psychiatric Hospital] at [Name of Hospital]. Taken off of psychiatric medications. Started on Geodon. Had EEG which showed seizure activity."</p> <p>On 2/7/14 at 2:15pm, a review of client #7's record and interview with the QIDP was conducted. The QIDP indicated client #7 was physically and verbally</p>			

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	<p>aggressive with staff and other clients both at the group home and at day services. The QIDP indicated the agency had made referrals for client #7 to BDDS for alternate placement.</p> <p>On 2/11/14 at 11:15am, an interview with the QIDP was conducted. The QIDP stated client #7 "was not appropriately placed at the group home" and "needed a more structured environment." The QIDP stated client #7's psychiatric physician had verbally stated to her that client #7 needed "to be in a different setting and not" at the group home. The QIDP stated the psychiatric professionals "stated [client #7] was not appropriate for the group home." The QIDP indicated during the past year client #7 had multiple psychiatric hospitalizations, multiple nursing home admissions, and continued to display physically aggressive behaviors which impacted the other clients who lived in the group home and client #7. The QIDP provided a review of client #7's undated behavioral tracking sheets. The QIDP indicated client #7's undated behavioral tracking sheets indicated rates for physical aggression were the following: 12/2013 was 102, 11/2013 was 216, 10/2013 was 162, 9/2013 was 162, 8/2013 was 67, and 7/2013 was 210. The QIDP</p>			

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	indicated client #7 began ECT in August, 2013 for her behavior of physical aggression. 9-3-7(a)				