

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G744	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/01/2012
NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2453 S 100 E PERU, IN 46970		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W0000	<p>This visit was for investigation of complaint #IN00118629.</p> <p>Complaint #IN00118629: Substantiated. Federal and state deficiencies related to the allegation are cited at W149, W153, W154, W159, W210, and W248.</p> <p>Dates of Survey: October 25, 26, 29, 30, 31, and November 1, 2012.</p> <p>Facility Number: 006630 Provider Number: 15G744 AIMS Number: 200902110</p> <p>Surveyor: Susan Eakright, Medical Surveyor III/QMRP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/8/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000			

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

TITLE

(X6) DATE

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

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on observation, record review, and interview for two (2) non reported allegations, the facility neglected to implement the facility's policy and procedure to report and to investigate allegations of abuse, neglect, and/or mistreatment for 1 of 3 sampled clients (client A).</p> <p>Findings include:</p> <p>On 10/25/12 from 6:50am until 8:40am, observation at the group home was completed. At 6:50am until 7:10am, client A requested a cigarette and to smoke six (6) times. At 7:10am, client A stated he had to have "a staff" person to be with him when he smoked "ever since I lit myself on fire." At 7:25am, client A went outside to smoke with Facility Staff (FS) #1. At 7:30am, client A stated "I used to carry my own cigarettes and lighter til a few days ago. I can't anymore cause it has something to do with setting myself on fire about a week ago." Client A stated "I didn't get hurt. I did it because I was unhappy at workshop." Client A stated "They make it difficult (to work and smoke). I got bossed. Ya need to</p>	W0149	<p>Following the incident, the Neglect, Battery and Exploitation of Individuals policy was reviewed with the QDDP. The QDDP and House Manager have a copy of the BDDS reportable guidelines. The QDDP was retrained on the "Investigation of Injury" form to be used for allegations, injuries and other investigatory purposes. All Residential Management staff have been retrained on contacting their supervisor immediately whenever allegations of abuse/neglect or misconduct by staff occurs. The policy will be reviewed again with the Direct Support Professionals at the staff meeting on 11/26/12. The QDDP understands that incident reports must be submitted within 24 hours. Staff was retrained that if incidents fall into the guidelines of abuse/neglect/exploitation, they will be reported to APS and the police in addition to BDDS. Families/Guardians will be notified of all BDDS reportable incidents. BDDS reports are shared agency wide to ensure proper communication. A communication notebook now goes back and forth between day programming and the group home so staff can document how client A's day has been and if there are any allegations being</p>	11/26/2012			

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	<p>have a choice to be happy (at work). I felt trapped (without) a choice. I lit my shirt on fire. I'll never do that again." Client A stated he had been unhappy at the workshop "for over six (6) months. [Name of Workshop Supervisor] bosses me and I don't get a choice." Client A stated he had told the staff at the group home and staff at the workshop that the workshop supervisor was bossing him and "rude" talking to him. At 7:40am, client A and FS #1 both indicated client A did not have a smoking plan. At 7:50am, the House Manager (HM) indicated client A did not have a smoking plan before the incident on 10/22/12 when client A set himself on fire at the workshop. The HM indicated client A independently carried his own lighter and cigarettes, and smoked independently before the incident. The HM indicated no smoking risk assessment had been completed. At 8:25am, client A left the group home for the workshop.</p> <p>On 10/25/12 from 8:40am until 10am, client A was observed at the local workshop. At 8:40am, the Workshop Supervisor (WKS) was interviewed and stated client A "doesn't like to be told what to do." WKS stated client A "did not have" a smoking plan, smoking schedule, and/or behavior management plan. From 8:40am until 9am, client A</p>		<p>investigated, behaviors observed that would be a cause for concern, issues that need reported to the administrator, etc. The corrective actions were completed and in place on November26, 2012.</p>				

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	<p>was observed to sit at his workstation on task and during the observation WKS walked up to client A twice to tell him items to do without providing a choice. At 9am, Workshop staff #2 provided client A's workshop record and indicated client A did not have a smoking plan, and/or smoking schedule, and/or a behavior management plan. At 9:45am, a workshop staff announced break. Client A got up from his workstation and indicated to his direct supervisor WKS #2 that he wanted to smoke. At 9:50am, Workshop Supervisor came into the break room where client A was with two other workshop staff and the Supervisor told client A to wait to smoke til the end of the break. Client A was not offered or encouraged to make a choice of when to smoke on break. At 9:55am, client A was observed outside the break area with the Workshop Supervisor smoking.</p> <p>On 10/25/12 at 9am, client A's workshop record included two behavior incidents: -10/22/12 at 8am "Behavior Report" indicated client A "came into workshop first thing this morning with verbal aggression and highly agitated." The report indicated client A told staff that group home staff "stole his cigarettes asked another consumer for cigarettes was told no more verbal aggression, cussing, threw his parts and walker (sic)." The</p>						

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	<p>report indicated client A "sat at workstation had lighter held his shirt and set it on fire (sic). Supervisor [name] put out the fire on his clothing and took [client A's] lighter." The report indicated client A was sent home for the day. -7/31/12 at 10am "Behavior Report" indicated client A "told a worker, staff was being mean because Supervisor asked him to please wait and staff would take him out for a smoke."</p> <p>On 10/25/12 at 10am, client A's additional workshop record was provided by the workshop supervisor (WKS). The WKS indicated this plan was not available for the workshop staff who worked with client A. The WKS provided a 2/7/12 "Individual Specifics for [client A]" which indicated "...Smoking Plan: [client A's] lighter may be kept on him or in his pouch on his walker during waking hours. While at workshop [client A] may hold on to his lighter. If [client A] begins to show unsafe smoking practices his lighter may be given to workshop staff for safe keeping. [Client A] will put cigarette butts in appropriate container when finished...Behavior Considerations [Client A] becomes easily frustrated when he feels that staff are discounting him or putting his needs aside. When staff are short with [client A] (sic) will lose his</p>						

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	<p>temper/patience very quickly. [Client A] has behaviors of yelling, swearing, and swinging and throwing his walker...." Client A's 12/5/11 letter from the Industrial Training Coordinator at workshop stated "[Client A] does not receive Behavior Management services at this time." At 10am, the Workshop Supervisor stated "The reports go to [Name of Agency in another city]" and he was not sure if client A's allegations were "ever" investigated.</p> <p>On 10/26/12 at 8am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports were reviewed from 07/01/12 through 10/26/12. There were no BDDS Reports and no investigations of client A's allegations of staff mistreatment towards him during behavior incidents on 7/31/12 or 10/22/12.</p> <p>On 10/26/12 at 8am, the facility's BDDS reports were reviewed from 7/1/12 through 10/26/12 and indicated the following for client A: -A 10/22/12 BDDS report, for an incident on 10/22/12 at 11:30am, indicated client A "removed a lighter from his pocket, held it to his shirt, and ignited the shirt causing flames 3-4 inches in height reaching up towards his stomach area. [Client A] pulled the shirt away from his</p>						

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	<p>stomach." The report indicated the Workshop Supervisor put out the fire. The report indicated client A stated "I don't care" as the Workshop Supervisor extinguished the flames with his hands and client A "sat in his chair laughing during the incident." The report indicated client A had no injuries.</p> <p>On 10/25/12 at 10:45am, a review of the facility's 5/11 Policy on Abuse, Neglect, and Exploitation "Prohibition of violations of Individual Rights" indicated, "Definitions...abuse: Intentional willful infliction...verbal or demonstrative harm caused by oral or written language or gestures with disparaging or derogatory implications...mental or emotional harm caused by unreasonable confinement, intimidation, humiliation...Neglect: Failure to provide supervision, training, appropriate care, food, medical care, or medical supervision to an individual...." The policy and procedure indicated "Reporting: It is the responsibility of any employee who possesses knowledge of an alleged case of neglect, battery, exploitation, or violation of individual rights to report it immediately."</p> <p>On 10/25/12 at 10:45am, a review of the facility's 5/2011 "Neglect, Battery, and Exploitation of Individuals" indicated "...Investigation of an alleged case of</p>				

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	<p>neglect, battery, exploitation of a person...or psychological abuse shall include, but not be limited to a statement from the complainant, a statement from the alleged violator, and any and all witnesses to the alleged incident...."</p> <p>On 10/25/12 at 11:30 AM an interview with the QMRP (Qualified Mental Retardation Professional) and the House Manager (HM) was conducted. Both staff indicated no investigations were available for review for client A's allegations on 10/22/12 or on 7/31/12. Both staff indicated the facility owned the day services. Both staff stated "all" allegations of abuse, neglect, and/or mistreatment "must" be reported and "must" be investigated. Both staff indicated neither allegation had been reported and investigated. Both indicated the indicated staff neglected to follow the abuse/neglect policy and procedure on reporting and investigating.</p> <p>This federal tag relates to complaint #IN00118629.</p> <p>9-3-2(a)</p>						

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W0153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on observation, record review, and interview for two (2) non reported allegations, the facility failed to report allegations of abuse, neglect, and/or mistreatment for 1 of 3 sampled clients (client A) in accordance with State Law.</p> <p>Findings include:</p> <p>On 10/25/12 from 6:50am until 8:40am, observation at the group home was completed. At 6:50am until 7:10am, client A requested a cigarette and to smoke six (6) times. At 7:10am, client A stated he had to have "a staff" person to be with him when he smoked "ever since I lit myself on fire." At 7:25am, client A went outside to smoke with Facility Staff (FS) #1. At 7:30am, client A stated "I used to carry my own cigarettes and lighter til a few days ago. I can't anymore cause it has something to do with setting myself on fire about a week ago." Client A stated "I didn't get hurt. I did it because I was unhappy at workshop." Client A stated "They make it difficult (to work</p>	W0153	Following the incident, the QDDP, House Manager and Direct Support staff were retrained on the importance of contacting the supervisor whenever allegations of abuse/neglect or misconduct by staff occurs. Additionally, the staff was retrained on the BDDS reportable guidelines. The QDDP understands the importance of reporting all incidents within 24 hours to the administrator and BDDS. All residential QDDP's have been trained on this procedure and will review at each group home. All residential employees will attend the agency wide BDDS reportable guidelines training annually in addition to their individual group home trainings. The Elder Justice Act guidelines are posted in the group home for staff to review. The corrective actions were completed and in place on November 26, 2012.	11/26/2012	

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	<p>and smoke). I got bossed. Ya need to have a choice to be happy (at work). I felt trapped (without) a choice. I lit my shirt on fire. I'll never do that again." Client A indicated he had been unhappy at the workshop "for over six (6) months. [Name of Workshop Supervisor] bosses me and I don't get a choice." Client A stated he had told the staff at the group home and staff at the workshop that the workshop supervisor was bossing him and "rude" talking to him. At 7:40am, client A and FS #1 both indicated client A did not have a smoking plan. At 7:50am, the House Manager (HM) indicated client A did not have a smoking plan before the incident on 10/22/12 when client A set himself on fire at the workshop. The HM indicated client A independently carried his own lighter and cigarettes, and smoked independently before the incident. The HM indicated no smoking risk assessment had been completed. At 8:25am, client A left the group home for workshop.</p> <p>On 10/25/12 at 9am, client A's workshop record included two behavior incidents and no BDDS reports: -10/22/12 at 8am "Behavior Report" indicated client A "came into workshop first thing this morning with verbal aggression and highly agitated." The report indicated client A told staff that</p>						

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	<p>group home staff "stole his cigarettes asked another consumer for cigarettes was told no more verbal aggression, cussing, threw his parts and walker (sic)." The report indicated client A "sat at workstation had lighter held his shirt and set it on fire (sic). Supervisor [name] put out the fire on his clothing and took [client A's] lighter." The report indicated client A was sent home for the day.</p> <p>-7/31/12 at 10am "Behavior Report" indicated client A "told a worker, staff was being mean because Supervisor asked him to please wait and staff would take him out for a smoke."</p> <p>On 10/25/12 at 10am, client A's additional workshop record was provided by the workshop supervisor (WKS). The Workshop Supervisor stated "the reports go to [Name of Agency in another city]" and he was not sure if client A's allegations were "ever" reported to BDDS (Bureau of Developmental Disabilities Services).</p> <p>On 10/26/12 at 8am, the facility's BDDS Reports were reviewed from 07/01/12 through 10/26/12. There were no BDDS Reports for client A's allegations of staff mistreatment towards him during behavior incidents on 7/31/12 or 10/22/12.</p>			

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	<p>On 10/25/12 at 11:30 AM an interview with the QMRP (Qualified Mental Retardation Professional) and the House Manager (HM) was conducted. Both staff indicated no reports were available for review for client A's allegations of staff mistreatment on 10/22/12 or on 7/31/12. Both staff stated "all" allegations of abuse, neglect, and/or mistreatment "must" be reported. Both staff indicated neither allegations had been reported to BDDS.</p> <p>This federal tag relates to complaint #IN00118629.</p> <p>9-3-2(a)</p>				

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on observation, record review, and interview for 1 of 6 BDDS (Bureau of Developmental Disabilities Services) reports and for two (2) additional non reported allegations, the facility failed to investigate allegations of abuse, neglect, and/or mistreatment for 1 of 3 sampled clients (client A).</p> <p>Findings include:</p> <p>On 10/25/12 from 6:50am until 8:40am, observation at the group home was completed. At 6:50am until 7:10am, client A requested a cigarette and to smoke six (6) times. At 7:10am, client A stated he had to have "a staff" person to be with him when he smoked "ever since I lit myself on fire." At 7:25am, client A went outside to smoke with Facility Staff (FS) #1. At 7:30am, client A stated "I used to carry my own cigarettes and lighter til a few days ago. I can't anymore cause it has something to do with setting myself on fire about a week ago." Client A stated "I didn't get hurt. I did it because I was unhappy at workshop." Client A stated "They make it difficult (to work and smoke). I got bossed. Ya need to</p>	W0154	<p>Direct care staff will be retrained on 11-26-12 that they are to notify a supervisor immediately when an allegation is made. The QDDP will thoroughly investigate all allegations and complete a BDDS report within 24 hours. The QDDP will notify the Director of Residential Services immediately following any allegations of abuse/neglect. The QDDP will complete a thorough investigation. The "investigation" form will be attached to the accident/incident and/or the BDDS report. All Residential QDDP's and day services staff has a copy of the form and has been trained on the importance of thoroughly investigating and notifying the QDDP of all injuries. BDDS reports are shared agency wide to ensure proper communication. The corrective actions were completed and in place on November 26, 2012.</p>	11/26/2012	

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	<p>have a choice to be happy (at work). I felt trapped (without) a choice. I lit my shirt on fire. I'll never do that again." Client A stated he had been unhappy at the workshop "for over six (6) months. [Name of Workshop Supervisor] bosses me and I don't get a choice." Client A stated he had told the staff at the group home and staff at the workshop that the workshop supervisor was bossing him and "rude" talking to him. At 7:50am, the House Manager (HM) indicated client A did not have a smoking plan before the incident on 10/22/12 when client A set himself on fire at the workshop. At 8:25am, client A left for workshop.</p> <p>On 10/25/12 at 9am, client A's workshop record included two behavior incidents and no investigations: -10/22/12 at 8am "Behavior Report" indicated client A "came into workshop first thing this morning with verbal aggression and highly agitated." The report indicated client A told staff that group home staff "stole his cigarettes asked another consumer for cigarettes was told no more verbal aggression, cussing, threw his parts and walker (sic)." The report indicated client A "sat at workstation had lighter held his shirt and set it on fire. Supervisor [name] put out the fire on his clothing and took [client A's] lighter (sic)." The report indicated</p>						

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	<p>client A was sent home for the day. -7/31/12 at 10am "Behavior Report" indicated client A "told a worker, staff was being mean because Supervisor asked him to please wait and staff would take him out for a smoke."</p> <p>On 10/25/12 at 10am, client A's additional workshop record was provided by the workshop supervisor (WKS). The Workshop Supervisor indicated the same agency who owned the group home owned the workshop. The Workshop Supervisor stated "the reports go to [Name of Agency in another city]" and he was not sure if client A's allegations were "ever" investigated.</p> <p>On 10/26/12 at 8am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports were reviewed from 07/01/12 through 10/26/12. There were no BDDS Reports and no investigations for client A's allegations of staff mistreatment towards him during behavior incidents on 7/31/12 or 10/22/12.</p> <p>On 10/26/12 at 8am, the facility's BDDS reports were reviewed from 7/1/12 through 10/26/12 and indicated the following for client A: -10/22/12 BDDS report, for an incident on 10/22/12 at 11:30am, indicated client</p>			

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	<p>A "removed a lighter from his pocket, held it to his shirt, and ignited the shirt causing flames 3-4 inches in height reaching up towards his stomach area. [Client A] pulled the shirt away from his stomach." The report indicated the Workshop Supervisor put out the fire. The report indicated client A stated "I don't care" as the Workshop Supervisor extinguished the flames with his hands and client A "sat in his chair laughing during the incident." The report indicated client A had no injuries. No investigation was available for review.</p> <p>On 10/25/12 at 11:30 AM an interview with the QMRP (Qualified Mental Retardation Professional) and the House Manager (HM) was conducted. Both staff indicated no investigations were available for review for client A's allegations on 10/22/12 or on 7/31/12. Both staff stated "all" allegations of abuse, neglect, and/or mistreatment "must" be investigated. Both staff indicated neither allegations had been.</p> <p>This federal tag relates to complaint #IN00118629.</p> <p>9-3-2(a)</p>						

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W0159	<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 observation, record review, and interview for 1 of 3 sampled clients (client A), the QMRP (Qualified Mental Retardation Professional) failed to monitor client A's progress and behavioral issues at the facility owned workshop.</p> <p>Findings include:</p> <p>On 10/25/12 from 6:50am until 8:40am, observation at the group home was completed. At 6:50am until 7:10am, client A requested a cigarette and to smoke six (6) times. At 7:10am, client A stated he had to have "a staff" person to be with him when he smoked "ever since I lit myself on fire." At 7:25am, client A went outside to smoke with Facility Staff (FS) #1. At 7:30am, client A stated "I used to carry my own cigarettes and lighter til a few days ago. I can't anymore cause it has something to do with setting myself on fire about a week ago." Client A stated "I didn't get hurt. I did it because I was unhappy at workshop." Client A stated "They make it difficult (to work and smoke). I got bossed. Ya need to have a choice to be happy (at work). I felt</p>	W0159	The Residential QDDP will send copies of any clients plans to day programming whenever there are changes or updates. To ensure more cohesive communication between the departments, the agency is in the process of becoming electronic. This would allow the various departments that care for the same consumer to have access to each others notes, care plans, records and documentation. This technology will allow for quick communication and a smaller margin of error. The system has already been implemented in some departments. The goal is to have the system agency wide within the next few months. The Residential QDDP would upload the new ISP, risk plan, etc and then day programming would instantly have access to that particular clients information. If an incident occurred at the workshop and Client A made a comment to a workshop supervisor, then the supervisor could post in Client A's notes section and the Residential staff could view and address immediately. Currently we are using the notebook back and forth each day along with direct observations by the House	11/19/2012	

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	<p>trapped (without) a choice. I lit my shirt on fire. I'll never do that again." Client A stated he had been unhappy at the workshop "for over six (6) months. [Name of Workshop Supervisor] bosses me and I don't get a choice." Client A stated he had told the staff at the group home and staff at the workshop that the workshop supervisor was bossing him and "rude" talking to him. At 7:40am, client A and FS #1 both indicated client A did not have a smoking plan. At 8:25am, client A left for workshop.</p> <p>On 10/25/12 from 8:40am until 10am, client A was observed at the local workshop. At 8:40am, the Workshop Supervisor (WKS) was interviewed and stated client A "doesn't like to be told what to do." WKS stated client A "did not have" a smoking plan, smoking schedule, and/or behavior management plan. From 8:40am until 9am, client A was observed to sit at his workstation on task and during the observation WKS walked up to client A twice to tell him items to do without providing a choice. At 9am, Workshop staff #2 provided client A's workshop record and indicated client A did not have a smoking plan, and/or smoking schedule, and/or a behavior management plan. At 9:45am, a workshop staff announced break. Client A got up from his workstation and</p>		<p>Manager and QDDP. The corrective actions were completed and in place on November 19, 2012.</p>	

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	<p>indicated to his direct supervisor WKS #2 that he wanted to smoke. At 9:50am, Workshop Supervisor came into the break room where client A was with two other workshop staff and the Supervisor told client A to wait to smoke til the end of the break. Client A was not offered or encouraged to make a choice of when to smoke on break. At 9:55am, client A was observed outside the break area with Workshop Supervisor smoking.</p> <p>On 10/25/12 at 10am, client A's additional workshop record was provided by the workshop supervisor (WKS). The WKS provided a 2/7/12 "Individual Specifics for [client A]" which indicated "...Smoking Plan: [client A's] lighter may be kept on him or in his pouch on his walker during waking hours. While at workshop [client A] may hold on to his lighter. If [client A] begins to show unsafe smoking practices his lighter may be given to workshop staff for safe keeping. [Client A] will put cigarette butts in appropriate container when finished...Behavior Considerations [Client A] becomes easily frustrated when he feels that staff are discounting him or putting his needs aside. When staff are short with [client A] will lose his temper/patience very quickly. [Client A] has behaviors of yelling, swearing, and swinging and throwing his walker...."</p>						

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	<p>Client A's 12/5/11 letter from the Industrial Training Coordinator at workshop stated "[Client A] does not receive Behavior Management services at this time." No QMRP monitoring and/or visits were available for review.</p> <p>On 10/25/12 at 11am, client A's record at the group home was reviewed. Client A's 11/17/11 ISP (Individual Support Plan) indicated he attended workshop full time daily. Client A's 5/2012 Behavior Management Plan (BMP) indicated client A had targeted behaviors of physical aggression, verbal aggression, and property destruction. Client A's record did not indicate QMRP monitoring and/or visits to the workshop.</p> <p>On 10/25/12 at 11:30 AM an interview with the QMRP (Qualified Mental Retardation Professional) and the House Manager (HM) was conducted. Both staff indicated they had visited workshop and indicated no documentation was available for review for the dates or subject of the visits. The QMRP and the HM indicated the workshop should have a copy of client A's ISP and BMP to follow at the workshop. The QMRP and HM both indicated they were not aware of client A's concerns and unhappiness at the workshop.</p>						

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	This federal tag relates to complaint #IN00118629. 9-3-3(a)				

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W0210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on observation, record review, and interview for 1 of 3 sampled clients (client A), the facility failed to reassess client A's functional ability to safely to carry his own lighter.</p> <p>Findings include:</p> <p>On 10/25/12 from 6:50am until 8:40am, observation at the group home was completed. At 6:50am until 7:10am, client A requested a cigarette and to smoke six (6) times. At 7:10am, client A stated he had to have "a staff" person to be with him when he smoked "ever since I lit myself on fire." At 7:25am, client A went outside to smoke with Facility Staff (FS) #1. At 7:30am, client A stated "I used to carry my own cigarettes and lighter til a few days ago. I can't anymore cause it has something to do with setting myself on fire about a week ago." Client A stated "I didn't get hurt. I did it because I was unhappy at workshop." Client A stated "They make it difficult (to work and smoke). I got bossed. Ya need to have a choice to be happy (at work). I felt</p>	W0210	Client A was reassessed for his ability to safely smoke and have access to his lighter. He will be re-evaluated again in this area in 6 months to ensure accuracy. His smoking plan has been revised to address safety concerns. The QDDP will assess and reassess consumers when there is a change in their status to ensure safety in all situations. Copies of the new assessment and smoking plan were given to day programming to train their staff. Day programming is offering Client A more opportunities to smoke throughout the day. The House Manager and QDDP will routinely observe Client A and workshop staff interacting in an effort to offer suggestions for a more harmonious work environment. Client A will be rewarded for going to work and given opportunities for choices when he has several good days. Immediately following the incident, Client A under went a Psychiatric evaluation and begun behavioral medication treatment. The corrective actions were completed and in place on November 19, 2012.	11/19/2012			

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	<p>trapped (without) a choice. I lit my shirt on fire. I'll never do that again." Client A stated he had been unhappy at the workshop "for over six (6) months. [Name of Workshop Supervisor] bosses me and I don't get a choice." At 7:40am, client A and FS #1 both indicated client A did not have a smoking plan. FS #1 indicated client A had a physician's order for staff to carry client A's lighter. At 7:50am, the House Manager (HM) indicated client A did not have a smoking plan before the incident on 10/22/12 when client A set himself on fire at the workshop. The HM indicated client A independently carried his own lighter and cigarettes, and smoked independently before the incident. The HM indicated no assessment of client A's functional ability to safely smoke had been completed. At 8:25am, client A left the group home for the workshop.</p> <p>On 10/25/12 from 8:40am until 10am, client A was observed at the local workshop. At 9am, the Workshop Supervisor stated client A "did not have" a smoking plan, smoking schedule, and/or behavior management plan. At 9am, Workshop staff #2 provided client A's workshop record and indicated client A did not have a smoking plan, and/or smoking schedule, and/or a behavior management plan. Workshop Staff #2</p>			

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	<p>indicated client A did not have an assessment for his functional ability to safely smoke. At 9:45am, a workshop staff announced break. Client A got up from his workstation and indicated to his direct supervisor WKS #2 that he wanted to smoke. At 9:50am, Workshop Supervisor came into the break room where client A was with two other workshop staff and the Supervisor told client A to wait to smoke til the end of the break. Client A was not offered or encouraged to make a choice of when to smoke on break. At 9:55am, client A was observed outside the break area with Workshop Supervisor smoking.</p> <p>On 10/25/12 at 9am, client A's workshop record included two behavior incidents: -10/22/12 at 8am "Behavior Report" indicated client A "came into workshop first thing this morning with verbal aggression and highly agitated." The report indicated client A told staff that group home staff "stole his cigarettes asked another consumer for cigarettes was told no more verbal aggression, cussing, threw his parts and walker (sic)." The report indicated client A "sat at workstation had lighter held his shirt and set it on fire (sic). Supervisor [name] put out the fire on his clothing and took [client A's] lighter." The report indicated client A was sent home for the day.</p>			

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	<p>-7/31/12 at 10am "Behavior Report" indicated client A "told a worker, staff was being mean because Supervisor asked him to please wait and staff would take him out for a smoke."</p> <p>On 10/25/12 at 10am, client A's additional workshop record was provided by the workshop supervisor (WKS). The WKS provided a 2/7/12 "Individual Specifics for [client A]" which indicated "...Smoking Plan: [client A's] lighter may be kept on him or in his pouch on his walker during waking hours. While at workshop [client A] may hold on to his lighter. If [client A] begins to show unsafe smoking practices his lighter may be given to workshop staff for safe keeping. [Client A] will put cigarette butts in appropriate container when finished...Behavior Considerations [Client A] becomes easily frustrated when he feels that staff are discounting him or putting his needs aside. When staff are short with [client A] will lose his temper/patience very quickly. [Client A] has behaviors of yelling, swearing, and swinging and throwing his walker...." Client A's 12/5/11 letter from the Industrial Training Coordinator at workshop stated "[Client A] does not receive Behavior Management services at this time."</p>						

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	<p>On 10/26/12 at 8am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 7/1/12 through 10/26/12 and indicated the following for client A:</p> <p>-10/22/12 BDDS report, for an incident on 10/22/12 at 11:30am, indicated client A "removed a lighter from his pocket, held it to his shirt, and ignited the shirt causing flames 3-4 inches in height reaching up towards his stomach area. [Client A] pulled the shirt away from his stomach." The report indicated the Workshop Supervisor put out the fire. The report indicated client A stated "I don't care" as the Workshop Supervisor extinguished the flames with his hands and client A "sat in his chair laughing during the incident."</p> <p>On 10/25/12 at 11am, client A's record at the group home was reviewed. Client A's 11/17/11 ISP (Individual Support Plan) indicated he attended workshop full time daily. Client A's 5/2012 Behavior Management Plan (BMP) indicated client A had targeted behaviors of physical aggression, verbal aggression, and property destruction. Client A's 4/30/12 "Risk Management Assessment and Plan," the 11/17/11 "Functional Assessment," and the 11/17/11 "Capacity for Independence" did not indicate client A had been assessed on his ability to</p>			

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	<p>smoke safely or to carry his own lighter independently. Client A's 10/2012 "Smoking Plan" indicated client A was "allowed to keep cigarettes in his possession, staff to assist to light cigarettes while smoking." Client A's 10/22/12 Emergency Room Physician's order indicated "Hold matches and/or lighter for 48 hrs. (hours)."</p> <p>On 10/25/12 at 11:30 AM an interview with the QMRP (Qualified Mental Retardation Professional) and the House Manager (HM) was conducted. Both staff indicated client A's ability to smoke safely had not been assessed before or after the 10/22/12 incident when he lit his shirt on fire.</p> <p>This federal tag relates to complaint #IN00118629.</p> <p>9-3-4(a)</p>						

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W0248	<p>483.440(c)(7) INDIVIDUAL PROGRAM PLAN</p> <p>A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients (client A) by not ensuring client A's ISP (Individual Support Plan) and (BSP) Behavior Support Plan were available at the day program he attended.</p> <p>Findings include:</p> <p>On 10/25/12 from 8:40am until 10am, client A was observed at the local workshop. At 9am, the Workshop Supervisor stated client A "did not have" an ISP or BSP available for review. At 9am, Workshop staff #2 provided client A's workshop record and indicated client A did not have an ISP, or smoking schedule, and/or a behavior management plan available for review.</p> <p>On 10/25/12 at 10am, client A's additional workshop record was provided by the workshop supervisor (WKS). The WKS provided a 2/7/12 "Individual Specifics for [client A]" which indicated "...Smoking Plan: [client A's] lighter may be kept on him or in his pouch on his walker during waking hours. While at workshop [client A] may hold on to his lighter. If [client A] begins to show unsafe smoking practices his lighter may be given to workshop staff for safe keeping. [Client A] will put cigarette butts in appropriate container when finished...Behavior Considerations [Client A] becomes easily frustrated when he feels that staff are discounting him or putting his needs aside. When staff are short with [client A] will lose his temper/patience very quickly. [Client A]</p>	W0248	Day programming has a copy of client A's plans. To ensure that each client's active treatment plan is integrated, coordinated and monitored, the Residential QDDP will send a copy electronically in addition to a hard copy. Then, the QDDP will follow up with the workshop caseworker to ensure they received the copies and have trained their staff accordingly. To ensure more cohesive communication between the departments, the agency is in the process of becoming electronic. This would allow the various departments that care for the same consumer to have access to each others notes, care plans, records and documentation. This technology will allow for quick communication and a small margin of error. The system has already been implemented in some departments. The goal is to have the system agency wide within the next few months. The corrective actions were completed and in place on November 19, 2012.	11/19/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G744	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/01/2012
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	<p>has behaviors of yelling, swearing, and swinging and throwing his walker...." Client A's 12/5/11 letter from the Industrial Training Coordinator at workshop indicated "[Client A] does not receive Behavior Management services at this time." Client A's ISP (Individual Support Plan) and Behavior Management Plan (BMP) were not available at the workshop. The WKS stated client A's 2/7/12 smoking plan was not available and was not implemented at the workshop by workshop staff.</p> <p>On 10/25/12 at 11am, client A's record at the group home was reviewed. Client A's 11/17/11 ISP (Individual Support Plan) indicated he attended workshop full time daily. Client A's 5/2012 Behavior Management Plan (BMP) indicated client A had targeted behaviors of physical aggression, verbal aggression, and property destruction. Client A's 4/30/12 "Risk Management Assessment and Plan," the 11/17/11 "Functional Assessment," and the 11/17/11 "Capacity for Independence" did not indicate client A was assessed for the risk and safety to smoke or to carry his own lighter independently. Client A's 10/2012 "Smoking Plan" indicated client A was "allowed to keep cigarettes in his possession, staff to assist to light cigarettes while smoking." Client A's 10/22/12 Emergency Room Physician's order indicated "Hold matches and/or lighter for 48 hrs. (hours)."</p> <p>On 10/25/12 at 11:30 AM an interview with the QMRP (Qualified Mental Retardation Professional) and the House Manager (HM) was conducted. Both indicated client A's ISP which included client A's smoking plan, and BMP should have been available and implemented at the workshop.</p> <p>This federal tag relates to complaint</p>			

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