

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G593	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/06/2015
NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342		
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W000000	<p>This visit was for an annual recertification and state licensure survey. This visit included the investigation of Complaint #IN00162350.</p> <p>COMPLAINT #IN00162350: SUBSTANTIATED, federal and state deficiencies related to the allegation are cited at W102, W104, W122, W149, W154, W157 and W159.</p> <p>Dates of Survey: January 30 and February 2, 3, 4, 5 and 6, 2015</p> <p>Facility number: 001107 Provider number: 15G593 AIM number: 100245570</p> <p>Surveyor: Christine Colon, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/16/15 by Ruth Shackelford, QIDP.</p>	W000000			

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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W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on record review and interview, the Governing Body failed to meet the Condition of Participation: Governing Body for 1 additional client (client H). The Governing Body neglected to develop and/or implement a system to prevent neglect and/or abuse of client H, by not ensuring the facility's staff provided supervision and transportation while at the hospital.</p> <p>Findings include:</p> <p>1. Please refer to W122. The governing body failed to meet the Condition of Participation: Client Protections for 1 additional client (client H). The governing body neglected to implement its written policy and procedures to prevent neglect of client H in regard to providing supervision and leaving client H at the hospital and not transporting him to the group home. The governing body neglected to put in place measures to prevent neglect and/or recurrence in</p>	W000102	<p>The facility currently has a written policy and procedure to identify report, thoroughly investigate and prevent neglect and/or abuse. All new employees and supervisors are trained on the policy and its full implementation there-of. The facility follows protocol including assessment of client behavioral supports and supervision levels to protect the clients.</p> <p>Refer to W104 and W 122 for additional strategies to ensure client protection.</p> <p>Responsible Staff: Program Director Completion Date: 3-8-15</p>	03/08/2015

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W000104	<p>regard to staff not providing supervision of client H and not transporting him to the group home.</p> <p>2. Please refer to W104. The governing body failed for 1 additional client (client H), to exercise general policy and operating direction over the facility to ensure thorough investigation of an allegation of neglect. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented and/or developed written policy and procedures to report allegations of neglect.</p> <p>This federal tag relates to complaint #IN00162350.</p> <p>9-3-1(a)</p> <p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 4 of 4 sampled clients and 4 additional clients (clients A, B, C, D, E, F, G and H), the facility's governing body failed to exercise general policy and</p>	W000104	The facility currently maintains a policy and procedure on mistreatment, neglect or abuse of a client and the reporting / investigation. All new employees are trained on the policy and the	03/08/2015

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	<p>operating direction over the facility to ensure routine maintenance was completed. The facility failed to provide toilet paper and towels/paper towels in the bathrooms. The facility's governing body failed to develop and implement policy and procedure to prevent neglect of client H and failed to put effective/corrective measures in place to prevent staff neglect of client H.</p> <p>Findings include:</p> <p>1. An observation was conducted at clients A, B, C, D, E, F, G and H's home on 1/30/15 from 6:15 A.M. until 8:00 A.M.. At 6:15 A.M., client B entered into the bathroom located off the living room. When client B exited the bathroom the bathroom did not have any toilet paper, towels or paper towels. At 6:25 A.M., client E used the bathroom located next to the medication administration area. When client E exited the bathroom, the bathroom did not have any toilet paper, towels or paper towels available for clients to use. During the observation the kitchen window was observed to have a 2 feet by 4 feet board in place of the glass window. The two screen door windows in the kitchen were observed to be broken out with pieces of glass around the perimeter of the frame.</p>		<p>procedure for protecting clients from harm. The facility follows protocol including assessment, review and revision of client behavioral supports to protect the clients. The facility routinely orders supplies to ensure needed hygiene items are available for client use. The facility maintenance person makes repairs in the group home as needed to ensure the client safety. The facility Program Director will train the home manager and staff to ensure necessary hygiene supplies such as paper toweling and soap are available for usage by the clients in the home. The Program Director will contact the maintenance person to follow up on the ordered windows to ensure replacement of broken windows in the home. Refer to W 149 Refer to W 154 Refer to W 157 In the future, the Home manager will review daily checklist to ensure the cleaning and hygiene supplies have been replenished. In addition, the Home Manager will list items in need of repair then contact the maintenance person to address those issues in a timely manner. Responsible Staff: Program Director Completion Date: 3-8-15</p>	

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	<p>An interview with the Group Home Manager (GHM) was conducted on 2/3/15 at 1:45 P.M.. The GHM indicated the windows were broken by client H during physical aggression in November 2014.</p> <p>An interview with the Area Director (AD) was conducted on 2/6/15 at 11:45 A.M.. The AD indicated the windows needed to be replaced and the further indicated the windows were ordered. The AD did not know when the windows would be replaced. The AD indicated toilet paper and paper towels should always be available in the bathroom for the clients' use.</p> <p>2. Please refer to 149: The facility neglected for 1 additional client (client H), to implement written policy and procedures to prevent neglect of a client by not providing supervision while in the Emergency Room (ER) and refusing to accept the client back to the group home after being discharged from the hospital. The facility neglected to conduct investigations in regard to neglect of client H.</p> <p>3. Please refer to W154: The facility neglected for 1 additional client (client H), to provide written evidence</p>						

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W000122	<p>investigations were conducted in regards to neglect.</p> <p>4. Please refer to W157: The facility neglected for 1 additional client (client H), to put sufficient/effective corrective measures in place in regard to preventing/addressing staff neglect.</p> <p>This federal tag relates to complaint #IN00162350.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based on record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 1 additional client (client H). The facility neglected to implement its written policy</p>	W000122	: The facility currently has protocols and policies mandated specifically to ensure the protection of clients within the facility. The facility currently mandates that all staff adhere to the policy and procedure on mistreatment, neglect or abuse to	03/08/2015

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	<p>and procedures to prevent neglect of client H in regard to neglecting to provide supervision. The facility neglected to put in place measures to prevent potential harm and/or recurrence in regard to neglect of client H. The facility neglected to provide written documentation to indicate investigations were conducted in regard to allegations of neglect.</p> <p>Findings include:</p> <p>1. Please refer to 149: The facility neglected for 1 additional client (client H), to implement written policy and procedures to prevent neglect of a client by not providing supervision while in the Emergency Room (ER) and refusing to accept the client back to the group home after being discharged from the hospital. The facility neglected to conduct investigations in regard to neglect of client H. The facility neglected to put sufficient/effective corrective measures in place in regard to preventing/addressing staff neglect.</p> <p>2. Please refer to W154: The facility neglected for 1 additional client (client H), to provide written evidence investigations were conducted in regards to allegations of neglect.</p>		<p>protect the clients. The procedures are carried out to prevent reoccurrence of the above. All new employees and supervisors are trained on the policy and the procedure for protecting clients from harm. The facility follows protocol including assessment, review and revision of client behavioral supports/protocols to protect the clients. The facility policy and procedure includes investigation of all incidents regarding alleged client abuse and or neglect.</p> <p>For additional corrections refer to W149, W154, W157.</p>	

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W000149	<p>3. Please refer to W157: The facility neglected for 1 additional client (client H), to put sufficient/effective corrective measures in place in regard to preventing/addressing staff neglect.</p> <p>This federal tag relates to complaint #IN00162350.</p> <p>9-3-2(a)</p> <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 for 1 additional client (client H), the facility neglected to implement written policy and procedures to prevent neglect of a client by not providing supervision while in the Emergency Room (ER) and refusing to accept the client back to the group home after being discharged from the hospital. The facility neglected to conduct investigations in regard to neglect of client H. The facility neglected to put sufficient/effective corrective measures in place to prevent/address staff neglect.</p>	W000149	<p>The facility currently has a written policy and procedure on mistreatment, neglect or abuse of a client, reporting, investigation and prevention of reoccurrence. All new employees are trained on the policy and the procedure for reporting injury of the clients to the proper authorities within and outside the agency. The facility follows a protocol including assessment of client behavioral support plans, program goals and individual support plan to ensure the client needs and protection is met. The facility will train the staff on the abuse/neglect policy including documentation, reporting unknown origin injuries</p>	03/08/2015			

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	<p>Findings include:</p> <p>A review of the facility's records was conducted at the facility's administrative office on 1/30/15 at 2:30 P.M.. Review of the Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated:</p> <p>-IR dated 11/6/14 involving client H indicated: "On 11/6/14, the police were called by neighbors because client H threw a brick and burst staff car window. 24. Section H: Incident Narrative Describe IN DETAIL the incident in chronological order. Include who, what, where when and how. Provide information on alleged injuries, interventions and current status. Report involvement of other parties such as law enforcement, emergency medical services. Include sources of information. When using names, include title and/or affiliation. See BDDS report." Further review of the report did not indicate any detailed information in regard to the incident. Review of the attached BDDS report dated 11/7/14 indicated: "On 11/7/14, [Program Director name (PD)] was contacted by a Social Worker (SW) at [Hospital #1 name], regarding an allegation of physical and verbal abuse</p>		<p>and investigation. The Home Manager and Program Director will be trained on detailed completion of BDDS incident reporting/investigation protocols, the abuse/neglect policy including documentation of incidents while on call, plus follow through to ensure corrective/protective measures are put in place to prevent reoccurrence of neglect incidents. The behavior plan for client H will be revised as the team deems necessary to address client behaviors and include steps to de-escalate client to prevent injuries to self and others. The staff will be trained on any revision of the client behavior support plan and on client H supervision level. The training will include the requirement to accompany clients to the hospital and ensuring the client safe return to the group home. The Area Director will ensure observations are completed in the home three times a week for 30 days and then twice a week routinely to ensure the staff are following the client plan and providing appropriate supervision. The facility will continue to train all employees to follow the reporting guidelines, of behavior plans as written and initiation of behavioral intervention techniques, charting of known and unknown injuries, calling supervisors per protocol as trained.</p>				

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	<p>the client made against two staffs (sic). The day before on 11/6/14, the police were called by a neighbor to the group home due to witnessing the client throw a brick three times, causing bodily damage and busting out the staffs (sic) car window. The police escorted the client to the hospital for a psych eval where the client stayed overnight and spoke with the SW the following morning reporting the allegations. The client was released from the hospital on 11/7/14 to return to the group home. The two staff have been suspended (removed from the schedule) pending an internal investigation of allegations of physical and verbal abuse."</p> <p>-IR dated 11/8/14 involving client H indicated: "First reported to [Facility name] Network on 11/8/14 at 7:49 P.M. By: No name noted....On 11/8/14, client was transported to [Hospital #1 name] for psych eval where he was admitted for threatening to kill everyone in his group home. Client was handcuffed by [Police Department name]....24. Section H: Incident Narrative Describe IN DETAIL the incident in chronological order. Include who, what, where when and how. Provide information on alleged injuries, interventions and current status. Report involvement of other parties such as law enforcement, emergency medical services. Include sources of information.</p>						

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	<p>When using names, include title and/or affiliation. See BDDS report." Further review of the report did not indicate any detailed information in regard to the incident." Review of the attached BDDS report indicated: "On 11/8/14 [Program Director name] received a call from staff stating that the client is a having a behavior to the point where he was pacing backward and forward through the house shouting that he was going to kill everyone in the house. the (sic) client then went outside of the home continuing to yell threats. The client started walking down the street going in and out of traffic with a staff following him trying to keep him safe. The police spotted the client and the staff walking down [Street name] and that is where they apprehended the client putting him in handcuffs due to his continued threats of killing everyone. The client was then taken to the home where the PD and the police waited on the ambulance to come get the client to take him back to the hospital for psych treatment. Currently the client is on the psych unit at [Hospital #2 name] where he was transported by medical transportation on 11/9/14. PD will continue to keep the team updated on the clients (sic) treatment."</p> <p>-IR dated 12/25/14 involving client H indicated: "On 12/25/14, Program</p>						

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	<p>Director wass (sic) called because [client H] was being escorted to the hospital for psych treatment due to threatening to kill everyone in the group home and elopement." Review of the attached BDDS report dated 12/25/14 indicated: "On 12/25/14 Program Director was called because [client H] was escorted to [Hospital #3] by [Police Department name] due to having elopment (sic) behaviors. [Client H] eloped from Group Home after threatening to kill everyone in the Group Home including clients and staff."</p> <p>-BDDS report dated 1/6/15 involving client H indicated: "On 1/6/15, Home Manager called Program Director because [client H] eloped from his Group Home. Director and Manager went out to assist each other in the pursuit of [client H], due to the weather being below zero, Program Director contacted [Police Department name] for assistance. The Police was (sic) able to locate [client H] and transport him to [Hospital #1] campus where he is currently receiving psych treatment."</p> <p>-BDDS report dated 1/7/15 involving client H indicated: "On 1/7/15, [client H] was discharged to retuned (sic) to the roup (sic) Home from [Hospital #1] where he had been treated due to having</p>			

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	<p>behaviors causing property damage to the group home and to staff vehicles. On 1/7/15, after being discharged to return home, [client H] went into a behavior of spitting on clients and staff, slamming doors, hitting walls, throwing objects at other clients, yelling and cursing at staff and clients, when staff asked him to stop and quite (sic) down. [Client H] attempted to attack female staff when male staff intervened. [Client H] did attack [Staff #13] causing him to need emergency assistance. [Client H] ran out the house, picked up a window unit air conditioner and threw it on top of staff (sic) vehicle, causing damages (sic). The [Police Department] were (sic) called, when they arrived, [client H] was still in his behavior and the police had to handcuff him to calm him down. [Client H] was taken back to the hospital where he was treated and released to the police. Currently [client H] is incarcerated in the [County Correctional Facility] awaiting to go before a Judge."</p> <p>A review of client H's Hospital records was conducted on 2/4/15 at 4:30 P.M.. Review of the record indicated the following:</p> <p>"[Hospital #1] Emergency Department Encounter dated 11/6/14 to 11/7/14 indicated: [Client H] is a 25 y.o. (year</p>						

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	old) male who presents to the emergency department with complaints of agitation. Patient reports he got into a verbal altercation with another member of his group home and told the member to 'take it outside.' Patient reports the member punched him in the face. Patient threw bricks through the other member's car windows after the altercation, and the police were called to the scene. Patient denies any suicidal or homicidal idealizations at this time. Patient denies any complaints at this time. Patient reports he does not like the group home he is currently in. If unable to provide, history then presented by patient and police....Pt (patient) presents from his group home. Staff called police after pt had an altercation with another person at the home. Staff states pt threw bricks through the windows of another person's car. Police were called and patient transported to ED. Pt states [Staff name #14] 'slapped him on the back of the head, shouting he's eating too fast.' He states '[Staff #15] needs to stop acting so fussy with him.' Pt is alert and oriented, not currently showing signs of agitation....Spoke with staff at group home. They state pt has never acted like this in the 2 years he has lived there. States 'he just snapped, took his shirt off, went walking in the road into traffic, stating he wanted to kill staff.' They state			

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	<p>they need him to be kept here....Spoke with house manager. States he will have the house call hospital for report on patient....Spoke with [PD], states they cannot take patient back into group home until he is further evaluated...Will contact house supervisor (hospital). House supervisor made aware of group home not wanting to take patient back tonight due to threat they feel towards other house members....Well developed, well nourished, no acute distress, non-toxic appearance very pleasant and is talking about how he wants to make a rap CD (compact disc)....Assessment/Plan: No acute work up necessary as patient is not currently agitated....ED (Emergency Department) Course: 7:29 P.M.: [Registered Nurse (RN)] discussed the patient's situation with patient's group home at length. Group Home is refusing to accept patient back stating he is a danger to other members of the home. Requests Psych consult and Depakote (Bipolar) level because this is a significant change in his baseline behavior. RN also spoke with [Hospital #2] who will not take the patient due to his lack of acute agitation. RN spoke with [Mental Health facility] who has no beds at this time....Discussed the patient with [Doctor name], accepts admission of patient."</p>						

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	<p>Review of ED Notes dated 11/8/14 to 11/13/14 indicated: "...Patient was transported to the Emergency Department per EMS (Emergency Medical Services) from group home....Per their executive director patient has been becoming increasingly violent and has not only threatened caregivers and other residents, but has also broken windows out of employee's cars and has walked through the neighborhood in a rage. Patient was admitted here yesterday, however, was released after testing. Patient is upset about both the redirection and tone of staff at the group home...Group Home states that patient may not return to their facility due to concerns regarding safety of staff and residents...Pt is calm today speaking well. He is limited and paranoid, and now is having issues with his placement. Social Services to call placement as this is their responsibility for his placement. Bipolar and limited cognitive function....Pt is sleeping better, still getting up early. Merits constant attention and guidance as he has cognitive impairments. Social Services to expedite discharge."</p> <p>Review of ED Notes dated 1/6/15 to 1/8/15 indicated: "[Client H]...presents to the emergency department via EMT from a group home. Per EMS, at the group home, patient became agitated,</p>						

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	<p>began running around shirtless and punched out a window. Patient stated he became angry because 'she gave me the wrong medicine and doesn't know what she is doing.'...Patient was involved in an altercation with caregivers at group home. Patient stated 'They jumped on me.' Patient has some abrasions to left hand. No other complaints at this time. Patient requesting a 'Big Pop.'...Pt discharged in stable condition via cart by [EMS]. This RN went over discharge instructions with pt and pt verbalizes understanding. Discharge instructions given to EMS for pt to take back to group home. Pt denies any further questions at this time. Pt is ambulatory to EMS cot with no s/s (signs and symptoms) of distress noted....Patient seen in the ED earlier this evening after becoming violent at his group home. While in ED the patient denies any homicidal or suicidal ideations, visual or auditory hallucinations. At that time the patient was cooperative, smiling and cooperative. I spoke with [Doctor name] and informed him of this and he agreed with discharge back to the group home. Ambulance service and the patient was (sic) discharged back to the group home. Upon arrival there the group home refused to allow the patient in the building. The personal (sic) there was a lady who noted she was pregnant and</p>			

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	<p>there alone and was unable to take care of the patient alone if he became violent again....The (sic) was brought back to the ED, via [EMS service] and informed me the group home would be able to take the patient back in the morning when there was more staff present. The patient returned still calm and cooperative....Spoke with [PD] from the group home. Informed her that she had 30 minutes to get someone here to pick up patient and that we would not be able to keep him in the ER till it was convenient for her...Pt returns to ER from group home via [EMS] because pregnant staff member states she has 7 other residents and does not want to deal with this patient per EMS. EMS also states staff at the group home contacted their supervisor to state the patient can't stay and the supervisor states to send the pt to another facility to be 'baby sat and we will pick him up in the morning.' Pt returns to ER cooperative and calm and has no complaints at this time. Pt returns to room 12 and has call light within reach....Discussion with behavioral health who states patient is not a candidate for admission due to combination of his intellectual disabilities and he previously harmed a staff member on the psychiatric unit...[Police department] arrived to receive the patient and were concerned regarding the patient's mental health and</p>			
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	<p>long term plan of care. [PD] was contacted...at this time she is refusing to accept the patient back into the group home due to concerns for safety of the other patients. She would like him discharged to [Police Department] to face court decision regarding his criminal charges. There was an extensive discussion between [Police Department] and [PD] regarding plan of care....Patient verbalized understanding of discharge instructions. Police are here to take patient to jail. Patient handcuffed and taken out of ED with a steady gait."</p> <p>A review of the facility's policy dated April 2011 was conducted on 2/4/15 at 4:00 P.M.. Review of the policy entitled "Quality and Risk Management" indicated: "Indiana Mentor promotes a high quality of service and seeks to protect individuals receiving Indiana Mentor Services through oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed. Indiana Mentor follows the BDDS Incident Reporting policy as outlined in the Provider Standards. An incident described as follows shall be reported to the BDDS on the incident report form prescribed by the BDDS. Alleged,</p>						

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	<p>suspected, or actual abuse, neglect, or exploitation of an individual. An incident in this category shall also be reported to Adult Protective Services....e. Failure to provide appropriate supervision, care or training. g. Failure to provide food and medical services as needed. Event with the potential for causing significant harm or injury and requiring medical or psychiatric treatments or services."</p> <p>An interview with Hospital Staff (HS) #1 was conducted on 2/2/15 at 1:15 P.M.. HS #1 indicated they were involved each time client H was transported to the ER. HS #1 indicated each time client H was transported by himself with no staff present to give client H's back ground/medical information. HS #1 indicated the hospital did not have a psych ward and further indicated the hospital made it aware to the facility. HS #1 indicated each time client H arrived to the ER he was calm with no agitation and could not be admitted to the hospital's sister hospital due to client H not having any agitation. HS #1 indicated each time they contacted the facility and spoke with the PD, GHM or staff, they were told they were not taking client H back. HS #1 indicated client H told ER staff he got agitated because staff at the group home yelled at him and hit him. HS #1</p>						

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	<p>indicated on 1/6/15 client H stayed almost 36 hours in the ER due to the facility refusing to accept him back to the group home.</p> <p>An interview with the GHM was conducted on 2/4/15 at 1:40 P.M.. The GHM indicated staff did not sit at the hospital with client H when he was transported to the hospital. The GHM indicated client H recently started displaying aggressive behaviors for no apparent reason. The GHM indicated client H did not target other clients at the group home, but was very physically aggressive towards staff at the group home. The GHM further indicated client H broke the group home windows and staff's car windows on several occasions.</p> <p>An interview with the Area Director (AD) was conducted on 2/6/15 at 11:45 A.M.. When asked if the facility staff should have provided supervision while client H was being treated at the ER, the AD indicated yes. The AD indicated the facility was trying to get assistance in getting client H admitted to the hospital due to his physical aggression. When asked if investigations were completed in regard to the incidents of staff neglecting to provide supervision and staff refusing to accept client H back at the group home after the hospital's numerous attempts of</p>						

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	<p>releasing him to the group home, the AD indicated she was not aware of the numerous attempts and further indicated there were no investigations conducted in regard to staff neglecting to provide supervision and refusing to accept client H back at the group home each time he was discharged from the hospital ER. The AD further indicated client H is currently incarcerated at the county jail.</p> <p>Please refer to W154: The facility neglected for 1 additional client (client H), to provide written evidence investigations were conducted in regards to allegations of neglect.</p> <p>Please refer to W157: The facility neglected for 1 additional client (client H), to put sufficient/effective corrective measures in place in regard to preventing/addressing staff neglect.</p> <p>This federal tag relates to complaint #IN00162350.</p> <p>9-3-2(a)</p>						

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W000154	<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 record review and interview for 1 additional client (client H), the facility failed to provide written evidence investigations were conducted in regards to allegations of neglect.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the facility's administrative office on 1/30/15 at 2:30 P.M.. Review of the Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated:</p> <p>-IR dated 11/8/14 involving client H indicated: "First reported to [Facility name] Network on 11/8/14 at 7:49 P.M. By: No name noted....On 11/8/14, client was transported to [Hospital #1 name] for psych eval where he was admitted for threatening to kill everyone in his group home. Client was handcuffed by [Police</p>	W000154	<p>The facility currently has a written policy and procedure for immediately reporting all allegations of mistreatment, neglect or abuse. The procedures include completion of a thorough investigation of a neglect allegation. All new employees are trained on the policy and the procedure for reporting any allegation of abuse or neglect. The facility follows a protocol and regulation for the supervisor to be notified and a BDDS report sent for any allegation of abuse or neglect plus completion and documentation of the investigation. The Area Director has trained the Program Director on the abuse and neglect policy and the requirements on how to conduct a complete and thorough investigation under state guidelines. In addition, the training covered ensuring detailed information in reports to the Bureau of Developmental Disabilities Services.. In the future, the facility will follow the protocol and the state regulation</p>	03/08/2015

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	<p>Department name]....24. Section H: Incident Narrative Describe IN DETAIL the incident in chronological order. Include who, what, where when and how. Provide information on alleged injuries, interventions and current status. Report involvement of other parties such as law enforcement, emergency medical services. Include sources of information. When using names, include title and/or affiliation. See BDDS report." Further review of the report did not indicate any detailed information in regard to the incident." Review of the attached BDDS report indicated: "On 11/8/14 [Program Director name] received a call from staff stating that the client is a having a behavior to the point where he was pacing backward and forward through the house shouting that he was going to kill everyone in the house. the (sic) client then went outside of the home continuing to yell threats. The client started walking down the street going in and out of traffic with a staff following him trying to keep him safe. The police spotted the client and the staff walking down [Street name] and that is where they apprehended the client putting him in handcuffs due to his continued threats of killing everyone. The client was then taken to the home where the PD and the police waited on the ambulance to come get the client to take him back to the hospital for psych</p>		<p>for the supervisor to be detailed in completing BDDS reports sent, plus completion and documentation of the investigation of client incidents. The Home manager will monitor the client daily support records three times weekly and follow up as needed. Responsible Staff: Area Director Completion Date: 3/8/15</p>				

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	<p>treatment. Currently the client is on the psych unit at [Hospital #2 name] where he was transported by medical transportation on 11/9/14. PD will continue to keep the team updated on the clients (sic) treatment." Further review of the report failed to indicate an investigation was conducted in regard to this incident.</p> <p>-IR dated 12/25/14 involving client H indicated: "On 12/25/14, Program Director was (sic) called because [client H] was being escorted to the hospital for psych treatment due to threatening to kill everyone in the group home and elopement." Review of the attached BDDS report dated 12/25/14 indicated: "On 12/25/14 Program Director was called because [client H] was escorted to [Hospital #3] by [Police Department name] due to having elopment (sic) behaviors. [Client H] eloped from Group Home after threatening to kill everyone in the Group Home including clients and staff." Further review of the record failed to indicate an investigation was conducted in regard to this incident.</p> <p>-BDDS report dated 1/6/15 involving client H indicated: "On 1/6/15, Home Manager called Program Director because [client H] eloped from his Group Home. Director and Manager went out to</p>						

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	<p>assist each other in the pursuit of [client H], due to the weather being below zero, Program Director contacted [Police Department name] for assistance. The Police was (sic) able to locate [client H] and transport him to [Hospital #1] campus where he is currently receiving psych treatment." Review of the record failed to indicate an investigation was completed in regard to this incident.</p> <p>-BDDS report dated 1/7/15 involving client H indicated: "On 1/7/15, [client H] was discharged to return (sic) to the group (sic) Home from [Hospital #1] where he had been treated due to having behaviors causing property damage to the group home and to staff vehicles. On 1/7/15, after being discharged to return home, [client H] went into a behavior of spitting on clients and staff, slamming doors, hitting walls, throwing objects at other clients, yelling and cursing at staff and clients, when staff asked him to stop and quite (sic) down. [Client H] attempted to attack female staff when male staff intervened. [Client H] did attack [Staff #13] causing him to need emergency assistance. [Client H] ran out the house, picked up a window unit air conditioner and threw it on top of staff (sic) vehicle, causing damages (sic). The [Police Department] were (sic) called, when they arrived, [client H] was still in</p>			

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	<p>his behavior and the police had to handcuff him to calm him down. [Client H] was taken back to the hospital where he was treated and released to the police. Currently [client H] is incarcerated in the [County Correctional Facility] awaiting to go before a Judge." Further review of the report failed to indicate an investigation was conducted in regard to this incident.</p> <p>A review of client H's Hospital records was conducted on 2/4/15 at 4:30 P.M.. Review of the record indicated the following:</p> <p>"[Hospital #1] Emergency Department Encounter dated 11/6/14 to 11/7/14 indicated: [Client H] is a 25 y.o. (year old) male who presents to the emergency department with complaints of agitation. Patient reports he got into a verbal altercation with another member of his group home and told the member to 'take it outside.' Patient reports the member punched him in the face. Patient threw bricks through the other member's car windows after the altercation, and the police were called to the scene. Patient denies any suicidal or homicidal idealizations at this time. Patient denies any complaints at this time. Patient reports he does not like the group home he is currently in. If unable to provide,</p>						

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	<p>history then presented by patient and police....Pt (patient) presents from his group home. Staff called police after pt had an altercation with another person at the home. Staff states pt threw bricks through the windows of another person's car. Police were called and patient transported to ED. Pt states [Staff name #14] 'slapped him on the back of the head, shouting he's eating too fast.' He states '[Staff #15] needs to stop acting so fussy with him.' Pt is alert and oriented, not currently showing signs of agitation....Spoke with staff at group home. They state pt has never acted like this in the 2 years he has lived there. States 'he just snapped, took his shirt off, went walking in the road into traffic, stating he wanted to kill staff.' They state they need him to be kept here....Spoke with house manager. States he will have the house call hospital for report on patient....Spoke with [PD], states they cannot take patient back into group home until he is further evaluated...Will contact house supervisor (hospital). House supervisor made aware of group home not wanting to take patient back tonight due to threat they feel towards other house members....Well developed, well nourished, no acute distress, non-toxic appearance very pleasant and is talking about how he wants to make a rap CD (compact disc)....Assessment/Plan: No</p>			

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	<p>acute work up necessary as patient is not currently agitated....ED (Emergency Department) Course: 7:29 P.M.: [Registered Nurse (RN)] discussed the patient's situation with patient's group home at length. Group Home is refusing to accept patient back stating he is a danger to other members of the home. Requests Psych consult and Depakote (Bipolar) level because this is a significant change in his baseline behavior. RN also spoke with [Hospital #2] who will not take the patient due to his lack of acute agitation. RN spoke with [Mental Health facility] who has no beds at this time....Discussed the patient with [Doctor name], accepts admission of patient." No written documentation was submitted for review to indicate an investigation was conducted in regard to staff neglecting to provide supervision and not allowing client H to return home.</p> <p>Review of ED Notes dated 1/6/15 to 1/8/15 indicated: "[Client H]...presents to the emergency department via EMT from a group home. Per EMS, at the group home, patient became agitated, began running around shirtless and punched out a window. Patient stated he became angry because 'she gave me the wrong medicine and doesn't know what she is doing.'...Patient was involved in an altercation with caregivers at group</p>						

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	<p>home. Patient stated 'They jumped on me.' Patient has some abrasions to left hand. No other complaints at this time. Patient requesting a 'Big Pop.'...Pt discharged in stable condition via cart by [EMS]. This RN went over discharge instructions with pt and pt verbalizes understanding. Discharge instructions given to EMS for pt to take back to group home. Pt denies any further questions at this time. Pt is ambulatory to EMS cot with no s/s (signs and symptoms) of distress noted....Patient seen in the ED earlier this evening after becoming violent at his group home. While in ED the patient denies any homicidal or suicidal ideations, visual or auditory hallucinations. At that time the patient was cooperative, smiling and cooperative. I spoke with [Doctor name] and informed him of this and he agreed with discharge back to the group home. Ambulance service and the patient was (sic) discharged back to the group home. Upon arrival there the group home refused to allow the patient in the building. The personal (sic) there was a lady who noted she was pregnant and there alone and was unable to take care of the patient alone if he became violent again....The (sic) was brought back to the ED, via [EMS service] and informed me the group home would be able to take the patient back in the morning when there</p>			
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	<p>was more staff present. The patient returned still calm and cooperative....Spoke with [PD] from the group home. Informed her that she had 30 minutes to get someone here to pick up patient and that we would not be able to keep him in the ER till it was convenient for her...Pt returns to ER from group home via [EMS] because pregnant staff member states she has 7 other residents and does not want to deal with this patient per EMS. EMS also states staff at the group home contacted their supervisor to state the patient can't stay and the supervisor states to send the pt to another facility to be 'baby sat and we will pick him up in the morning.' Pt returns to ER cooperative and calm and has no complaints at this time. Pt returns to room 12 and has call light within reach....Discussion with behavioral health who states patient is not a candidate for admission due to combination of his intellectual disabilities and he previously harmed a staff member on the psychiatric unit....[Police department] arrived to receive the patient and were concerned regarding the patient's mental health and long term plan of care. [PD] was contacted...at this time she is refusing to accept the patient back into the group home due to concerns for safety of the other patients. She would like him discharged to [Police Department] to face</p>			

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	<p>court decision regarding his criminal charges. There was an extensive discussion between [Police Department] and [PD] regarding plan of care...Patient verbalized understanding of discharge instructions. Police are here to take patient to jail. Patient handcuffed and taken out of ED with a steady gait." No written documentation was submitted for review to indicate an investigation was conducted in regard to this incident of neglect.</p> <p>An interview with the Area Director (AD) was conducted on 2/6/15 at 11:45 A.M.. The AD indicated all allegations of abuse and neglect and injuries of unknown origin should be investigated. When asked if the above incidents were investigated, the AD indicated if the incidents were investigated the investigations would have been submitted. No investigations were submitted for review in regards to the mentioned incidents.</p> <p>This federal tag relates to complaint #IN00162350.</p> <p>9-3-2(a)</p>						

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 additional client (client H), the facility failed to take sufficient/effective corrective measures in regard to preventing/addressing staff neglect.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the facility's administrative office on 1/30/15 at 2:30 P.M.. Review of the Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated:</p> <p>1. -IR dated 11/6/14 involving client H indicated: "On 11/6/14, the police were called by neighbors because client H threw a brick and burst staff car window. 24. Section H: Incident Narrative Describe IN DETAIL the incident in chronological order. Include who, what, where when and how. Provide information on alleged injuries, interventions and current status. Report involvement of other parties such as law enforcement, emergency medical services. Include sources of information.</p>	W000157	The facility currently has a written policy and procedure for immediately reporting all allegations of mistreatment, neglect or abuse and injuries of unknown origin. The procedures include completion of a thorough investigation of the origin of an injury. All new employees are trained on the policy and the procedure for reporting injury. The facility follows a protocol and regulation for the supervisor to be notified and a BDDS report sent for injuries of unknown origin, plus completion and documentation of the investigation of said unknown origin injury. The Area Director has trained the Program Director on the requirement to investigate incidents and the need to put corrective measures in place to prevent recurrence as required by regulation. In addition, the training covered ensuring detailed information in reports to the Bureau of Developmental Disabilities Services.. In the future, the facility will follow the protocol and the state regulation for the supervisor to be detailed in completing BDDS reports sent, plus completion and documentation of the investigation of client incidents	03/08/2015			

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	<p>When using names, include title and/or affiliation. See BDDS report." Further review of the report did not indicate any detailed information in regard to the incident. Review of the attached BDDS report dated 11/7/14 indicated: "On 11/7/14, [Program Director name (PD)] was contacted by a Social Worker (SW) at [Hospital #1 name], regarding an allegation of physical and verbal abuse the client made against two staffs (sic). The day before on 11/6/14, the police were called by a neighbor to the group home due to witnessing the client throw a brick three times, causing bodily damage and busting out the staffs (sic) car window. The police escorted the client to the hospital for a psych eval where the client stayed overnight and spoke with the SW the following morning reporting the allegations. The client was released from the hospital on 11/7/14 to return to the group home. The two staff have been suspended (removed from the schedule) pending an internal investigation of allegations of physical and verbal abuse."</p> <p>-IR dated 11/8/14 involving client H indicated: "First reported to [Facility name] Network on 11/8/14 at 7:49 P.M. By: No name noted....On 11/8/14, client was transported to [Hospital #1 name] for psych eval where he was admitted for threatening to kill everyone in his group</p>		<p>including the need to put corrective measures in place to prevent recurrence. The Area Director and Quality Assurance Specialist will monitor incident reports for the need of investigations and to ensure that corrective measures have been put in place to prevent recurrence of any violation. Responsible Staff: Area Director Completion Date: 3/8/15</p>				

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	<p>home. Client was handcuffed by [Police Department name]...24. Section H: Incident Narrative Describe IN DETAIL the incident in chronological order. Include who, what, where when and how. Provide information on alleged injuries, interventions and current status. Report involvement of other parties such as law enforcement, emergency medical services. Include sources of information. When using names, include title and/or affiliation. See BDDS report." Further review of the report did not indicate any detailed information in regard to the incident." Review of the attached BDDS report indicated: "On 11/8/14 [Program Director name] received a call from staff stating that the client is a having a behavior to the point where he was pacing backward and forward through the house shouting that he was going to kill everyone in the house. the (sic) client then went outside of the home continuing to yell threats. The client started walking down the street going in and out of traffic with a staff following him trying to keep him safe. The police spotted the client and the staff walking down [Street name] and that is where they apprehended the client putting him in handcuffs due to his continued threats of killing everyone. The client was then taken to the home where the PD and the police waited on the ambulance to come get the client to</p>			
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	<p>take him back to the hospital for psych treatment. Currently the client is on the psych unit at [Hospital #2 name] where he was transported by medical transportation on 11/9/14. PD will continue to keep the team updated on the clients (sic) treatment."</p> <p>-IR dated 12/25/14 involving client H indicated: "On 12/25/14, Program Director was (sic) called because [client H] was being escorted to the hospital for psych treatment due to threatening to kill everyone in the group home and elopement." Review of the attached BDDS report dated 12/25/14 indicated: "On 12/25/14 Program Director was called because [client H] was escorted to [Hospital #3] by [Police Department name] due to having elopment (sic) behaviors. [Client H] eloped from Group Home after threatening to kill everyone in the Group Home including clients and staff."</p> <p>-BDDS report dated 1/6/15 involving client H indicated: "On 1/6/15, Home Manager called Program Director because [client H] eloped from his Group Home. Director and Manager went out to assist each other in the pursuit of [client H], due to the weather being below zero, Program Director contacted [Police Department name] for assistance. The</p>			

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	<p>Police was (sic) able to locate [client H] and transport him to [Hospital #1] campus where he is currently receiving psych treatment."</p> <p>-BDDS report dated 1/7/15 involving client H indicated: "On 1/7/15, [client H] was discharged to returned (sic) to the group (sic) Home from [Hospital #1] where he had been treated due to having behaviors causing property damage to the group home and to staff vehicles. On 1/7/15, after being discharged to return home, [client H] went into a behavior of spitting on clients and staff, slamming doors, hitting walls, throwing objects at other clients, yelling and cursing at staff and clients, when staff asked him to stop and quite (sic) down. [Client H] attempted to attack female staff when male staff intervened. [Client H] did attack [Staff #13] causing him to need emergency assistance. [Client H] ran out the house, picked up a window unit air conditioner and threw it on top of staff (sic) vehicle, causing damages (sic). The [Police Department] were called, when they arrived, [client H] was still in his behavior and the police had to handcuff him to calm him down. [Client H] was taken back to the hospital where he was treated and released to the police. Currently [client H] is incarcerated in the [County Correctional Facility] awaiting</p>				

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	<p>to go before a Judge."</p> <p>A review of client H's Hospital records was conducted on 2/4/15 at 4:30 P.M.. Review of the record indicated the following:</p> <p>"[Hospital #1] Emergency Department Encounter dated 11/6/14 to 11/7/14 indicated: [Client H] is a 25 y.o. (year old) male who presents to the emergency department with complaints of agitation. Patient reports he got into a verbal altercation with another member of his group home and told the member to 'take it outside.' Patient reports the member punched him in the face. Patient threw bricks through the other member's car windows after the altercation, and the police were called to the scene. Patient denies any suicidal or homicidal idealizations at this time. Patient denies any complaints at this time. Patient reports he does not like the group home he is currently in. If unable to provide, history then presented by patient and police....Pt (patient) presents from his group home. Staff called police after pt had an altercation with another person at the home. Staff states pt threw bricks through the windows of another person's car. Police were called and patient transported to ED. Pt states [Staff name #14] 'slapped him on the back of the</p>				

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	<p>head, shouting he's eating too fast.' He states '[Staff #15] needs to stop acting so fussy with him.' Pt is alert and oriented, not currently showing signs of agitation....Spoke with staff at group home. They state pt has never acted like this in the 2 years he has lived there. States 'he just snapped, took his shirt off, went walking in the road into traffic, stating he wanted to kill staff.' They state they need him to be kept here....Spoke with house manager. States he will have the house call hospital for report on patient....Spoke with [PD], states they cannot take patient back into group home until he is further evaluated...Will contact house supervisor (hospital). House supervisor made aware of group home not wanting to take patient back tonight due to threat they feel towards other house members....Well developed, well nourished, no acute distress, non-toxic appearance very pleasant and is talking about how he wants to make a rap CD (compact disc)....Assessment/Plan: No acute work up necessary as patient is not currently agitated....ED (Emergency Department) Course: 7:29 P.M.: [Registered Nurse (RN)] discussed the patient's situation with patient's group home at length. Group Home is refusing to accept patient back stating he is a danger to other members of the home. Requests Psyche consult and Depakote</p>				

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	<p>(Bipolar) level because this is a significant change in his baseline behavior. RN also spoke with [Hospital #2] who will not take the patient due to his lack of acute agitation. RN spoke with [Mental Health facility] who has no beds at this time....Discussed the patient with [Doctor name], accepts admission of patient."</p> <p>Review of ED Notes dated 11/8/14 to 11/13/14 indicated: "...Patient was transported to the Emergency Department per EMS (Emergency Medical Services) from group home....Per their executive director patient has been becoming increasingly violent and has not only threatened caregivers and other residents, but has also broken windows out of employee's cars and has walked through the neighborhood in a rage. Patient was admitted here yesterday, however, was released after testing. Patient is upset about both the redirection and tone of staff at the group home...Group Home states that patient may not return to their facility due to concerns regarding safety of staff and residents...Pt is calm today speaking well. He is limited and paranoid, he is having issues with his placement. Social Services to call placement as this is their responsibility for his placement. Bipolar and limited cognitive function....Pt is sleeping better,</p>				

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	<p>still getting up early. Merits constant attention and guidance as he has cognitive impairments. Social Services to expedite discharge."</p> <p>Review of ED Notes dated 1/6/15 to 1/8/15 indicated: "[Client H]...presents to the emergency department via EMT from a group home. Per EMS, at the group home, patient became agitated, began running around shirtless and punched out a window. Patient stated he became angry because 'she gave me the wrong medicine and doesn't know what she is doing.'...Patient was involved in an altercation with caregivers at group home. Patient stated 'They jumped on me.' Patient has some abrasions to left hand. No other complaints at this time. Patient requesting a 'Big Pop.'...Pt discharged in stable condition via cart by [EMS]. This RN went over discharge instructions with pt and pt verbalizes understanding. Discharge instructions given to EMS for pt to take back to group home. Pt denies any further questions at this time. Pt is ambulatory to EMS cot with no s/s (signs and symptoms) of distress noted....Patient seen in the ED earlier this evening after becoming violent at his group home. While in ED the patient denies any homicidal or suicidal ideations, visual or auditory hallucinations. At that time the patient</p>						

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	<p>was cooperative, smiling and cooperative. I spoke with [Doctor name] and informed him of this and he agreed with discharge back to the group home. Ambulance service and the patient were discharged back to the group home. Upon arrival there the group home refused to allow the patient in the building. The personal (sic) there was a lady who noted she was pregnant and there alone and was unable to take care of the patient alone if he became violent again....The (sic) was brought back to the ED, via [EMS service] and informed me the group home would be able to take the patient back in the morning when there was more staff present. The patient returned still calm and cooperative....Spoke with [PD] from the group home. Informed her that she had 30 minutes to get someone here to pick up patient and that we would not be able to keep him in the ER till it was convenient for her...Pt returns to ER from group home via [EMS] because pregnant staff member states she has 7 other residents and does not want to deal with this patient per EMS. EMS also states staff at the group home contacted their supervisor to state the patient can't stay and the supervisor states to send the pt to another facility to be 'baby sat and we will pick him up in the morning.' Pt returns to ER cooperative and calm and</p>				

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	<p>has no complaints at this time. Pt returns to room 12 and has call light within reach....Discussion with behavioral health who states patient is not a candidate for admission due to combination of his intellectual disabilities and he previously harmed a staff member on the psychiatric unit...[Police department] arrived to receive the patient and were concerned regarding the patient's mental health and long term plan of care. [PD] was contacted...at this time she is refusing to accept the patient back into the group home due to concerns for safety of the other patients. She would like him discharged to [Police Department] to face court decision regarding his criminal charges. There was an extensive discussion between [Police Department] and [PD] regarding plan of care....Patient verbalized understanding of discharge instructions. Police are here to take patient to jail. Patient handcuffs and taken out of ED with a steady gait."</p> <p>No documentation was available for review to indicate the facility took sufficient/effective corrective action to prevent recurrence of staff neglecting to provide supervision while at the ER and neglected to transport him back from the hospital.</p> <p>An interview with Hospital Staff (HS) #1</p>				

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	<p>was conducted on 2/2/15 at 1:15 P.M.. HS #1 indicated they were involved each time client H was transported to the ER. HS #1 indicated each time client H was transported by himself with no staff present to give client H's back ground/medical information. HS #1 indicated the hospital did not have a psych ward and further indicated the hospital made it aware to the facility. HS #1 indicated each time client H arrived to the ER he was calm with no agitation and could not be admitted to the hospital's sister hospital due to client H not having any agitation. HS #1 indicated each time they contacted the facility and spoke with the PD, GHM or staff, they were told they were not taking client H back. HS #1 indicated client H told ER staff he got agitated because staff at the group home yelled at him and hit him. HS #1 indicated on 1/6/15 client H stayed almost 32 hours in the ER due to the facility refusing to accept him back to the group home.</p> <p>An interview with the GHM was conducted on 2/4/15 at 1:40 P.M.. The GHM indicated staff did not sit at the hospital with client H when he was transported to the hospital. The GHM indicated client H recently started displaying aggressive behaviors for no apparent reason. The GHM indicated</p>						

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	<p>client H did not target other clients at the group home, but was very physically aggressive towards staff at the group home. The GHM further indicated client H broke the group home windows on staff's car windows on several occasions. The GHM indicated client H is currently incarcerated at the county jail.</p> <p>An interview with the Area Director (AD) was conducted on 2/6/15 at 11:45 A.M.. When asked if the facility addressed the documented incidents of staff neglecting to provide supervision and transportation to and from the hospital, the AD indicated there was no written documentation to indicate measures were put in place to prevent recurrence of staff neglecting to provide supervision and transportation. The AD further indicated client H is currently incarcerated at the county jail.</p> <p>This federal tag relates to complaint #IN00162350.</p> <p>9-3-2(a)</p>				

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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 PD/Qualified Intellectual Disabilities Professional (PD/QIDP) failed for 1 additional client (client H), to coordinate services and ensure measures were put in place to prevent neglect.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the facility's administrative office on 1/30/15 at 2:30 P.M.. Review of the Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records indicated:</p> <p>-IR dated 11/6/14 involving client H indicated: "On 11/6/14, the police were called by neighbors because client H threw a brick and burst staff car window.</p>	W000159	The facility currently has a written policy and procedure for immediately reporting all allegations of mistreatment, neglect or abuse and injuries of unknown origin. The procedures include completion of a thorough investigation of abuse, neglect and injuries of unknown origin. All new employees are trained on the policy and the procedure for reporting abuse, neglect and injuries of unknown origin. The facility employes a PD/QIDP to oversee each clients active treatment program to integrate, coordinate and monitor. The Area Director has trained the PD/QIDP to investigate and document findings of such such invesigations. The training also covered ensuring detailed information in reports to the Bureau of Developmental Disabilities Services. In addition to the PD/QIDP has been trained to ensure that after the completion of the investigation	03/08/2015

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	<p>24. Section H: Incident Narrative Describe IN DETAIL the incident in chronological order. Include who, what, where when and how. Provide information on alleged injuries, interventions and current status. Report involvement of other parties such as law enforcement, emergency medical services. Include sources of information. When using names, include title and/or affiliation. See BDDS report." Further review of the report did not indicate any detailed information in regard to the incident. Review of the attached BDDS report dated 11/7/14 indicated: "On 11/7/14, [Program Director name (PD)] was contacted by a Social Worker (SW) at [Hospital #1 name], regarding an allegation of physical and verbal abuse the client made against two staffs (sic). The day before on 11/6/14, the police were called by a neighbor to the group home due to witnessing the client throw a brick three times, causing bodily damage and busting out the staffs (sic) car window. The police escorted the client to the hospital for a psych eval where the client stayed overnight and spoke with the SW the following morning reporting the allegations. The client was released from the hospital on 11/7/14 to return to the group home. The two staff have been suspended (removed from the schedule) pending an internal investigation of</p>		<p>that measure are put in place to prevent recurrence of violation. The Area Directo and Quality Assurance Specialist will monitor incident reports for the need of investigations and to ensure that corrective measures have been put in place to prevent recurrence of any violations. The Area Director has trained the Program Director on the requirement to investigate incidents as required by regulation. In addition, the training covered ensuring detailed information in reports to the Bureau of Developmental Disabilities Services.. In the future, the facility will follow the protocol and the state regulation for the supervisor to be detailed in completing BDDS reports sent, plus completion and documentation of the investigation of client incidents. The Home manager will monitor the client daily support records three times weekly and follow up as needed. Responsible Staff: Area Director Completion Date: 3/8/15</p>				

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	<p>allegations of physical and verbal abuse."</p> <p>-IR dated 11/8/14 involving client H indicated: "First reported to [Facility name] Network on 11/8/14 at 7:49 P.M. By: No name noted....On 11/8/14, client was transported to [Hospital #1 name] for psych eval where he was admitted for threatening to kill everyone in his group home. Client was handcuffed by [Police Department name]....24. Section H: Incident Narrative Describe IN DETAIL the incident in chronological order. Include who, what, where when and how. Provide information on alleged injuries, interventions and current status. Report involvement of other parties such as law enforcement, emergency medical services. Include sources of information. When using names, include title and/or affiliation. See BDDS report." Further review of the report did not indicate any detailed information in regard to the incident." Review of the attached BDDS report indicated: "On 11/8/14 [Program Director name] received a call from staff stating that the client is a having a behavior to the point where he was pacing backward and forward through the house shouting that he was going to kill everyone in the house. the (sic) client then went outside of the home continuing to yell threats. The client started walking down the street going in and out of traffic</p>			

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	<p>with a staff following him trying to keep him safe. The police spotted the client and the staff walking down [Street name] and that is where they apprehended the client putting him in handcuffs due to his continued threats of killing everyone. The client was then taken to the home where the PD and the police waited on the ambulance to come get the client to take him back to the hospital for psych treatment. Currently the client is on the psych unit at [Hospital #2 name] where he was transported by medical transportation on 11/9/14. PD will continue to keep the team updated on the clients (sic) treatment."</p> <p>-IR dated 12/25/14 involving client H indicated: "On 12/25/14, Program Director wass (sic) called because [client H] was being escorted to the hospital for psych treatment due to threatening to kill everyone in the group home and elopement." Review of the attached BDDS report dated 12/25/14 indicated: "On 12/25/14 Program Director was called because [client H] was escorted to [Hospital #3] by [Police Department name] due to having elopment (sic) behaviors. [Client H] eloped from Group Home after threatening to kill everyone in the Group Home including clients and staff."</p>						

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	<p>-BDDS report dated 1/6/15 involving client H indicated: "On 1/6/15, Home Manager called Program Director because [client H] eloped from his Group Home. Director and Manager went out to assist each other in the pursuit of [client H], due to the weather being below zero, Program Director contacted [Police Department name] for assistance. The Police was (sic) able to locate [client H] and transport him to [Hospital #1] campus where he is currently receiving psych treatment."</p> <p>-BDDS report dated 1/7/15 involving client H indicated: "On 1/7/15, [client H] was discharged to returned (sic) to the group (sic) Home from [Hospital #1] where he had been treated due to having behaviors causing property damage to the group home and to staff vehicles. On 1/7/15, after being discharged to return home, [client H] went into a behavior of spitting on clients and staff, slamming doors, hitting walls, throwing objects at other clients, yelling and cursing at staff and clients, when staff asked him to stop and quite (sic) down. [Client H] attempted to attack female staff when male staff intervened. [Client H] did attack [Staff #13] causing him to need emergency assistance. [Client H] ran out the house, picked up a window unit air conditioner and threw it on top of staff</p>				

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	<p>(sic) vehicle, causing damages (sic). The [Police Department] were (sic) called, when they arrived, [client H] was still in his behavior and the police had to handcuff him to calm him down. [Client H] was taken back to the hospital where he was treated and released to the police. Currently [client H] is incarcerated in the [County Correctional Facility] awaiting to go before a Judge."</p> <p>A review of client H's Hospital records was conducted on 2/4/15 at 4:30 P.M.. Review of the record indicated the following:</p> <p>"[Hospital #1] Emergency Department Encounter dated 11/6/14 to 11/7/14 indicated: [Client H] is a 25 y.o. (year old) male who presents to the emergency department with complaints of agitation. Patient reports he got into a verbal altercation with another member of his group home and told the member to 'take it outside.' Patient reports the member punched him in the face. Patient threw bricks through the other member's car windows after the altercation, and the police were called to the scene. Patient denies any suicidal or homicidal idealizations at this time. Patient denies any complaints at this time. Patient reports he does not like the group home he is currently in. If unable to provide,</p>						

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	<p>history then presented by patient and police....Pt (patient) presents from his group home. Staff called police after pt had an altercation with another person at the home. Staff states pt threw bricks through the windows of another person's car. Police were called and patient transported to ED. Pt states [Staff name #14] 'slapped him on the back of the head, shouting he's eating too fast.' He states '[Staff #15] needs to stop acting so fussy with him.' Pt is alert and oriented, not currently showing signs of agitation....Spoke with staff at group home. They state pt has never acted like this in the 2 years he has lived there. States 'he just snapped, took his shirt off, went walking in the road into traffic, stating he wanted to kill staff.' They state they need him to be kept here....Spoke with house manager. States he will have the house call hospital for report on patient....Spoke with [PD], states they cannot take patient back into group home until he is further evaluated...Will contact house supervisor (hospital). House supervisor made aware of group home not wanting to take patient back tonight due to threat they feel towards other house members....Well developed, well nourished, no acute distress, non-toxic appearance very pleasant and is talking about how he wants to make a rap CD (compact disc)....Assessment/Plan: No</p>			

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	<p>acute work up necessary as patient is not currently agitated....ED (Emergency Department) Course: 7:29 P.M.: [Registered Nurse (RN)] discussed the patient's situation with patient's group home at length. Group Home is refusing to accept patient back stating he is a danger to other members of the home. Requests Psych consult and Depakote (Bipolar) level because this is a significant change in his baseline behavior. RN also spoke with [Hospital #2] who will not take the patient due to his lack of acute agitation. RN spoke with [Mental Health facility] who has no beds at this time....Discussed the patient with [Doctor name], accepts admission of patient."</p> <p>Review of ED Notes dated 11/8/14 to 11/13/14 indicated: "...Patient was transported to the Emergency Department per EMS (Emergency Medical Services) from group home....Per their executive director patient has been becoming increasingly violent and has not only threatened caregivers and other residents, but has also broken windows out of employee's cars and has walked through the neighborhood in a rage. Patient was admitted here yesterday, however, was released after testing. Patient is upset about both the redirection and tone of staff at the group home...Group Home</p>						

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	<p>states that patient may not return to their facility due to concerns regarding safety of staff and residents...Pt is calm today speaking well. He is limited and paranoid, and now is having issues with his placement. Social Services to call placement as this is their responsibility for his placement. Bipolar and limited cognitive function....Pt is sleeping better, still getting up early. Merits constant attention and guidance as he has cognitive impairments. Social Services to expedite discharge."</p> <p>Review of ED Notes dated 1/6/15 to 1/8/15 indicated: "[Client H]...presents to the emergency department via EMT from a group home. Per EMS, at the group home, patient became agitated, began running around shirtless and punched out a window. Patient stated he became angry because 'she gave me the wrong medicine and doesn't know what she is doing.'...Patient was involved in an altercation with caregivers at group home. Patient stated 'They jumped on me.' Patient has some abrasions to left hand. No other complaints at this time. Patient requesting a 'Big Pop.'...Pt discharged in stable condition via cart by [EMS]. This RN went over discharge instructions with pt and pt verbalizes understanding. Discharge instructions given to EMS for pt to take back to group</p>			

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	<p>home. Pt denies any further questions at this time. Pt is ambulatory to EMS cot with no s/s (signs and symptoms) of distress noted....Patient seen in the ED earlier this evening after becoming violent at his group home. While in ED the patient denies any homicidal or suicidal ideations, visual or auditory hallucinations. At that time the patient was cooperative, smiling and cooperative. I spoke with [Doctor name] and informed him of this and he agreed with discharge back to the group home. Ambulance service and the patient was (sic) discharged back to the group home. Upon arrival there the group home refused to allow the patient in the building. The personal (sic) there was a lady who noted she was pregnant and there alone and was unable to take care of the patient alone if he became violent again....The (sic) was brought back to the ED, via [EMS service] and informed me the group home would be able to take the patient back in the morning when there was more staff present. The patient returned still calm and cooperative....Spoke with [PD] from the group home. Informed her that she had 30 minutes to get someone here to pick up patient and that we would not be able to keep him in the ER till it was convenient for her...Pt returns to ER from group home via [EMS] because pregnant</p>			
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	<p>staff member states she has 7 other residents and does not want to deal with this patient per EMS. EMS also states staff at the group home contacted their supervisor to state the patient can't stay and the supervisor states to send the pt to another facility to be 'baby sat and we will pick him up in the morning.' Pt returns to ER cooperative and calm and has no complaints at this time. Pt returns to room 12 and has call light within reach....Discussion with behavioral health who states patient is not a candidate for admission due to combination of his intellectual disabilities and he previously harmed a staff member on the psychiatric unit...[Police department] arrived to receive the patient and were concerned regarding the patient's mental health and long term plan of care. [PD] was contacted...at this time she is refusing to accept the patient back into the group home due to concerns for safety of the other patients. She would like him discharged to [Police Department] to face court decision regarding his criminal charges. There was an extensive discussion between [Police Department] and [PD] regarding plan of care....Patient verbalized understanding of discharge instructions. Police are here to take patient to jail. Patient handcuffed and taken out of ED with a steady gait."</p>			

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	<p>Review of the records failed to indicate the facility's Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) ensured staff supervised client H while at the hospital and failed to ensure transportation to the group home and services were provided to client H.</p> <p>An interview with Hospital Staff (HS) #1 was conducted on 2/2/15 at 1:15 P.M.. HS #1 indicated they were involved each time client H was transported to the ER. HS #1 indicated each time client H was transported by himself with no staff present to give client H's back ground/medical information. HS #1 indicated the hospital did not have a psych ward and further indicated the hospital made it aware to the facility. HS #1 indicated each time client H arrived to the ER he was calm with no agitation and could not be admitted to the hospital's sister hospital due to client H not having any agitation. HS #1 indicated each time they contacted the facility and spoke with the PD, GHM or staff, they were told they were not taking client H back. HS #1 indicated client H told ER staff he got agitated because staff at the group home yelled at him and hit him. HS #1 indicated on 1/6/15 client H stayed almost 36 hours in the ER due to the facility refusing to accept him back to the</p>						

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	<p>group home.</p> <p>An interview with the GHM was conducted on 2/4/15 at 1:40 P.M.. The GHM indicated staff did not sit at the hospital with client H when he was transported to the hospital. The GHM indicated client H recently started displaying aggressive behaviors for no apparent reason. The GHM indicated client H did not target other clients at the group home, but was very physically aggressive towards staff at the group home. The GHM further indicated client H broke the group home windows and staff's car windows on several occasions.</p> <p>An interview with the Area Director (AD) was conducted on 2/6/15 at 11:45 A.M.. When asked if the facility's PD/QIDP addressed the documented incidents of staff neglecting to provide supervision and transportation to and from the hospital, the AD indicated there was no written documentation to indicate measures were put in place to prevent recurrence of staff neglecting to provide supervision and transportation. The AD further indicated client H is currently incarcerated at the county jail.</p> <p>This federal tag relates to complaint #IN00162350.</p>				

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W000220	<p>9-3-3(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include speech and language development.</p> <p>Based on observation, record review and interview, the facility failed for 3 of 4 sampled clients (clients A, B and D) to ensure a speech assessment/reassessment was completed for clients who required assistance with communication skills.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 1/30/15 from 6:15 A.M. until 8:00 A.M.. During the entire observation clients A, B and D were non-verbal in communication in that the clients were limited to some one word answers that could not be understood. There was no communication teaching or training for clients A, B and D during this observation.</p> <p>An evening observation was conducted at the group home on 2/3/15 from 6:30 P.M. until 8:00 P.M.. During the entire observation clients A, B and D were</p>	W000220	<p>The facility currently meets with the client interdisciplinary team 30 days after admission and at least annually to review assessment of the client progress and areas for potential needs. The facility nurse reviews the assessment to ensure the medical needs of the clients are met.</p> <p>The Program Director and facility nurse will review the client records for assessments needed. The home manger and nurse will schedule the needed client assessments including speech evaluations for clients A, B and D. In addition the Program Director will ensure each client has the appropriate assessments completed and in the client file. The Area Director will train the nurse and home manager to complete a monthly list of client appointments and assessments needed to ensure all clients receive the care required.</p> <p>In the future, the Program Director and the facility nurse will review what assessments are required for each person prior to the client annual review date and on-going throughout the year. The Program Director will complete goals that</p>	03/08/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G593		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/06/2015	
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	<p>non-verbal in communication in that the clients were limited to some one word answers that could not be understood. There was no communication teaching or training for clients A, B and D during this observation.</p> <p>A review of client A's record was conducted on 2/3/15 at 12:00 P.M.. Review of client A's Individual Support Plan (ISP) dated 10/24/14 and/or record indicated he required assistance with communication. The record indicated a most current "Speech Evaluation" dated 7/29/03. There was no written documentation to indicate client A's speech/communication had been reevaluated since 7/29/03.</p> <p>A review of client B's record was conducted on 2/3/15 at 12:30 P.M.. Review of client B's ISP dated 5/21/14 and/or record indicated he required assistance with communication. The record failed to indicate client B's speech/communication had been evaluated. There was no written documentation to indicate client B's speech/communication had been evaluated.</p> <p>A review of client D's record was conducted on 2/3/15 at 1:30 P.M.. Review of client D's ISP dated 12/11/14</p>		<p>correspond with needs of the client based on the outcome of the assessments as needed. The Program Director will review a list of client needed appointments and follow up to ensure they have been carried out.</p> <p>Responsible Staff: Area Director Completion Date: 3/8/15</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G593	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/06/2015
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W000249	<p>and/or record indicated he required assistance with communication. The record failed to indicate client D's speech/communication had been evaluated. There was no written documentation to indicate client D's speech/communication had been evaluated.</p> <p>An interview with the facility nurse was conducted on 2/6/15 at 11:45 A.M.. The nurse indicated there was no documentation to indicate clients A, B and D's speech and/or language skills had been assessed/reassessed.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION 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. Based on observation, interview and record review for 3 of 4 sampled clients (clients A, B and D), the facility failed to</p>	W000249	: The facility meets with the Interdisciplinary Team to determine the specific objectives necessary to meet the client's	03/08/2015
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G593		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/06/2015	
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	<p>implement the clients' Individual Support Plan (ISPs) objectives when formal and/or informal opportunities for training existed.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 1/30/15 from 6:15 A.M. until 8:00 A.M.. During the entire observation clients A, B and D were non-verbal in communication in that the clients were limited to some one word answers that could not be understood. There was no communication teaching or training for clients A, B and D during this observation. From 6:15 A.M. until 7:10 A.M., clients A and B sat in the living room with no meaningful activity and client D sat in his bedroom with no meaningful activity. The clients did not assist in meal preparation or setting the table. Client D was not encouraged to wear his eyeglasses and ate at a separate table located off the living room away from his peers. Direct Support Professional (DSP) #1 was assisting other clients in their bedrooms and DSP #3 prepared breakfast and DSP #2 administered medications.</p> <p>A review of client A's record was conducted on 2/3/15 at 12:00 P.M.. The Individual Support Plan (ISP) dated</p>		<p>needs. The client goals and objectives are based on client and team input as well as comprehensive assessment results incorporated in the comprehensive functional assessment of the Individual Support Plan. the Program Director has trained the direct support employees to implement the client's objectives and goals formally and on informal opportunities as well. The training included providing meaningful activity, engaging the client in daily activities including meal preparation, setting the table, and formal goal instruction. The goals for clients A, B and D were reviewed to ensure the clients are encouraged to wear eyeglasses, communicate, cook, practice safety, etc. In the future, the facility Home Manager will complete observations to ensure the clients are challenged according to their abilities and ensure client goals are being implemented. The Home Manager will monitor the goal implementation and documentation on a three times weekly basis. The program director will review goals on a weekly basis. Responsible Person: Area Director Completion Date: 3/8/15</p>				

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	<p>10/24/14 indicated the following training objectives could have been implemented during the observation: "Will increase his communication skills by responding to staff questions... Will set the table."</p> <p>A review of client B's records was conducted on 2/3/15 at 12:30 P.M.. The ISP dated 5/21/14 indicated the following training objectives could have been implemented during the observation: "Will increase his communication skills by learning appropriate and inappropriate response... Will increase his cooking skills by taking the dish out of the freezer... Will increase his knowledge of emergency safety skills.."</p> <p>A review of client D's records was conducted on 2/3/15 at 2:30 P.M.. The ISP dated 12/11/14 indicated the following training objectives could have been implemented during the observation: "Will make a healthy choice at mealtime... Will increase wearing his eyeglasses... Will set the table... Will be encouraged to eat with others at meal time."</p> <p>An interview with the Area Director (AD) was conducted on 2/6/15 at 11:45 A.M.. The AD indicated the facility staff should implement clients A, B and D's training objectives at all times of</p>				

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W000323	<p>opportunity.</p> <p>9-3-4(a)</p> <p>483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview, the facility failed for 2 of 4 sampled clients (clients A and D) to have hearing evaluations as recommended by the physician.</p> <p>Findings include:</p> <p>A review of client A's record was conducted on 2/3/15 at 12:00 P.M.. Client A's record indicated a most current hearing evaluation dated 3/29/13 which indicated: "Mild hearing loss." Client A's current annual physical dated 10/2/14 indicated "Requires further evaluation by appropriate specialist of hearing." Client A's record did not contain evidence he had a hearing evaluation completed as recommended by his physician.</p>	W000323	The facility schedules a annual physical exam and other treatments within a year of the previous treatment per regulations. The facility healthcare system that is overseen by the facility nurse. Each client medical care plan is based on assessments, doctor's orders, diagnosis requiring protocol and the needs of the client. The facility nurse has scheduled hearing evaluations for clients A and D as recommended by the physician. The nurse will be re- trained to check all doctor appointments, assessments and labs in the future to ensure the clients receive the necessary treatment. In the future, the facility nurse will review the evaluations, medical appointments and labs for each client. The nurse will make a list for all clients with scheduled	03/08/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G593		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/06/2015	
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	<p>A review of client D's record was conducted on 2/3/15 at 1:30 P.M.. Client D's annual physical dated 10/2/14 indicated "Requires further evaluation of hearing." Client D's record indicated a most current hearing evaluation dated 7/31/13. Client D's record did not contain evidence he had a hearing evaluation completed as recommended by his physician.</p> <p>The facility's nurse was interviewed on 2/6/15 at 11:45 A.M.. The nurse indicated clients A and D did not have hearing evaluations completed as recommended by their physician.</p> <p>9-3-6(a)</p>		<p>dates to share with the home manager and program director at least monthly on-going throughout the year. The Program Director will review a list of client needed appointments monthly and follow up to ensure they have been carried out. Responsible Staff: Area Director Completion Date: 3/8/15</p>				
W000331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 2 of 4 sampled clients (clients B and D), the facility's nursing staff failed to ensure facility staff were adequately trained and showed competency in regard to documenting/tracking clients B and D's bowel movements. The facility's nursing staff failed to ensure staff documented</p>	W000331	<p>The facility has an established healthcare system that is overseen by the facility nurse. Each client medical care plan is based on assessments, doctor's orders, diagnosis requiring protocol and the needs of the client. The facility staff have been trained in the monitoring and documentation of client bowel</p>	03/08/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G593	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/06/2015
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	<p>client D's weights as ordered by his physician. The facility's nursing staff failed to ensure staff documented client B's blood pressure readings. The facility's nursing staff failed to monitor each client's constipation to prevent blockage on a more frequent basis.</p> <p>Findings include:</p> <p>1. A review of client B's record was conducted on 2/3/15 at 12:30 P.M.. A review of client B's "Constipation Protocol" dated 8/24/14 indicated: "Incontinent of bowel/bladder. Usually has BM (Bowel Movement) daily. Document BMs? Yes If yes, where? MAR (Medication Administration Record. If document BMs, how/ Observed....PRN (as needed) bowel medications: If no BM for 3 days or hard stools noted, Give Milk of Magnesia, 2 tbs (tablespoons) every 4 hours as needed. Notify nurse of use. If no BM after 8 hours after receiving Milk of Magnesia notify nurse....After following PRN order, if no stool by the end of 1st day, call supervisor and R.N. (Registered Nurse)...If person has 'no' or only small stool in 3 days, call Supervisor and R.N....Document incident in Medical notes, Incident Report and DSR (Daily Service Report)."</p>		<p>movements, weights, and blood pressure readings. The facility nurse and home manager will be trained by the Area Director to check documentation to ensure the staff are completing the medical based procedures listed above.</p> <p>In the future the facility nurse will review the MARs weekly to ensure the medical procedures of the clients are being implemented. The Home manger will review the MARs three times weekly while following up to ensure all procedures listed in the MAR and protocols are implemented.</p> <p>Responsible Staff: Program Director Completion Date: 3/8/15</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G593	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/06/2015
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	<p>A review of client B's Physician Orders (PO) dated 11/1/4 to 2/15 indicated to document client B's bowel movements daily. A review of client B's bowel tracking sheets indicated: No documented bowel movement on 11/1/14, 11/2/14, 11/3/14, 11/4/14, 11/5/14, 11/6/14, 11/7/14, 11/8/14, 11/9/14, 11/10/14, 12/15/14, 12/16/14, 12/17/14, 12/18/14, 12/19/14, 12/20/14, 12/21/14, 12/22/14, 12/26/14, 12/27/14, 12/28/14, 12/29/14, 12/30/14 and 12/21/14. There was no documentation to indicate the nurse reviewed the bowel tracking.</p> <p>A review of client B's Physician Orders (PO) dated 2/14 to 2/15 indicated: "Blood Pressure...Blood Pressure to be checked weekly, initial and record on MAR chart." Review of client B's MAR dated 11/14 indicated no blood pressure documentation on 11/23/14 and 11/30/14. Review of the record failed to indicate client B's blood pressure was checked weekly as ordered by his physician.</p> <p>2. A review of client D's record was conducted on 2/3/15 at 1:30 P.M.. Review of client D's "Constipation Protocol" dated 8/24/14 indicated:</p> <p>"Incontinent of bowel/bladder. Usually has BM (Bowel Movement) daily.</p>			

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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342			
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	<p>Document BMs? Yes If yes, where? MAR (Medication Administration Record. If document BMs, how/ Observed....PRN (as needed) bowel medications: If no BM for 3 days or hard stools noted, Give Milk of Magnesia, 2 tbs (tablespoons) every 4 hours as needed. Notify nurse of use. If no BM after 8 hours after receiving Milk of Magnesia notify nurse....After following PRN order, if no stool by the end of 1st day, call supervisor and R.N. (Registered Nurse)...If person has 'no' or only small stool in 3 days, call Supervisor and R.N....Document incident in Medical notes, Incident Report and DSR (Daily Service Report)."</p> <p>A review of client D's bowel tracking sheets for 2014 indicated: No documented bowel movement on 12/26/14, 12/27/14, 12/28/14, 12/29/14, 12/30/14 and 12/31/14. There was no documentation to indicate the supervisor or RN was contacted as directed in his "Constipation Protocol" dated 8/24/14. There was no documentation to indicate the nurse reviewed the bowel tracking</p> <p>A review of client D's Physician Orders (PO) dated 1/14 to 2/15 indicated: "Weight...Weight to be done every Sunday morning, initial and record on</p>						

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W000336	<p>MAR chart." Review of client D's MAR dated 9/14 indicated no weight documentation on 9/18/14. Review of the record failed to indicate client D was weighed every Sunday as ordered by his physician.</p> <p>An interview with the facility's nurse was conducted on 2/6/15 at 11:45 A.M.. The nurse indicated all staff are to document clients B and D's bowel movements as indicated in their protocols. The nurse indicated there was no written documentation to indicate the facility notified the physician of clients B and D's lack of bowel movements. The nurse indicated there was no documentation available for review to indicate the facility's nursing services monitored clients B and D's bowel movements, blood pressures and weights.</p> <p>9-3-6(a)</p> <p>483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more</p>						

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	<p>frequent basis depending on client need.</p> <p>Based on record review and interview for 1 of 3 sampled clients (client B), the facility's nursing services failed to conduct quarterly nursing assessments of the client's health status and medical needs.</p> <p>Findings include:</p> <p>A review of client B's record was conducted on 2/3/15 at 12:30 P.M.. Client B's record indicated no nursing quarterlies were completed for 5/14. Client B's most current annual physical was dated 2/19/14. Client B's 6/11/14 medical record indicated client B's diagnoses included, but were not limited to, Seizures, Eczema, Constipation, Hypertension, Organic Brain Syndrome and incontinence. Client B's 2/15 physician orders indicated client B received routine medications.</p> <p>An interview with the facility's nurse was conducted on 2/6/15 at 11:45 A.M.. The nurse indicated nursing quarterlies are to be completed every three months. The nurse further indicated there was no written evidence to indicate nursing quarterly was completed every three months.</p>	W000336	<p>The facility has an established healthcare system that is overseen by the facility nurse. The nurse reviews the clients charts including appointment summary, doctor's orders and overall treatment. The nurse documents progress of the client medical status on a monthly and quarterly basis as required by regulation. The facility nurse has been re-trained to complete quarterly health reviews for each client as required by regulations. In the future the facility nurse will complete client medical reviews quarterly ensuring they are available in the client book. The QIDP will review the nurse's quarterly client summaries on a quarterly basis to ensure the completion and thorough content. Responsible Staff: Program Director/Nurse Completion Date: 3/8/15</p>	03/08/2015			

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W000436	<p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review and interview, the facility failed for 2 of 4 sampled clients (clients B and D) who were prescribed eyeglasses, to encourage and teach them to wear their eye glasses.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 1/30/15 from 6:15 A.M. until 8:00 A.M.. During the observation periods clients B and D did not and were not prompted to wear their eyeglasses.</p> <p>An evening observation was conducted on 2/3/15 from 4:00 P.M. until 5:30 P.M.. During the observation periods clients B and D did not and were not prompted to wear their eyeglasses.</p> <p>A review of client B's record was conducted on 2/3/15 at 12:30 P.M..</p>	W000436	<p>The facility will furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces and other devices identified by the interdisciplinary team as needed by the client. The program director has trained the staff to encourage client's B and D to wear their glasses per doctor's order. The direct support professionals training included ensuring the implement of the goal for both clients to wear the eyeglasses. In the future, the staff and home manager will assist the clients to make informed choices to wear their glasses. In addition, the home manager will complete active treatment observations 3 times weekly to ensure goals are being implemented. Person Responsible: Program Director Completion Date: 3/8/15</p>	03/08/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G593	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/06/2015
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W000440	<p>Review of client B's record indicated a most current vision evaluation dated 7/29/14 which indicated "Recommend wear eyeglasses full time."</p> <p>A review of client D's record was conducted on 2/3/15 at 1:30 P.M.. Review of client D's record indicated a most current vision evaluation dated 6/24/14 which indicated "Compound Hyperopic astigmatism (both focal lines are located behind the retina) prescription for new glasses." The Individual Support Plan (ISP) dated 12/11/14 indicated "Will increase wearing his eyeglasses."</p> <p>An interview with the Area Director (AD) was conducted on 2/6/15 at 11:45 A.M.. The AD indicated staff should have prompted clients B and D to wear their eyeglasses.</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel.</p>			

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NAME OF PROVIDER OR SUPPLIER REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342		
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W000455	<p>Based on record review and interview, the facility failed to conduct evacuation drills which affected 8 of 8 clients living in the facility (clients A, B, C, D, E, F, G and H).</p> <p>Findings include:</p> <p>The facility's records were reviewed on 2/3/15 at 2:33 P.M.. The review failed to indicate the facility held an evacuation drill for clients A, B, C, D, E, F, G and H during the morning staff shift (8:00 A.M. to 4:00 P.M.) for the first quarter (January 1st through March 31st) of 2014.</p> <p>The Area Director (AD) was interviewed on 2/6/15 11:45 A.M.. The AD indicated evacuation drills are to be conducted during each quarter for each shift of personnel. The AD further indicated there was no written documentation to indicate the facility conducted evacuation drills during each quarter for each staff shift.</p> <p>9-3-7(a)</p> <p>483.470(l)(1) INFECTION CONTROL There must be an active program for the</p>	W000440	<p>A fire drill schedule has been developed to inform Home Managers as to when drills are to be completed. This schedule allows for a drill to be completed for each shift of work every quarter as well as to allow for a barricade drill to be completed at least every quarter. The Home Manager has been trained of the necessity of ensuring that the safety drills are completed as scheduled on a monthly basis.</p> <p>In the future, the Home Manager will adhere to the calendar of drills to ensure the group home staff have completed a evacuation drill at the designated time and date to meet safety guidelines. The Program Director will review the evacuation drills monthly to ensure completion and follow up as needed.</p> <p>Person Responsible: Program Director, Completion Date: 3/8/15</p>	03/08/2015	

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	<p>prevention, control, and investigation of infection and communicable diseases. Based on observation and interview, the facility failed to maintain proper hygiene practices and prevent cross contamination, for 4 of 4 sampled clients and 3 additional clients (clients A, B, C, D, E, F and G) observed during medication administration and meal time.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 1/30/15 from 6:15 A.M. until 8:00 A.M.. At 6:25 A.M., Direct Support Professional (DSP) #2 prompted client E to the medication area for her morning medication administration. Client E walked into the bathroom located next to the medication office, used the bathroom and walked into the medication area. Client E did not and was not prompted to wash her hands after using the bathroom and prior to medication administration. At 6:30 A.M., DSP #2 administered client E's medications. At 6:33 A.M., the bathroom was observed to not have any hand soap or towels/paper towels. At 6:35 A.M., client C was prompted by DSP #3 to set the dining table. Client C did not and was not prompted to wash his hands. Client C retrieved plates, cups and tableware and placed each item on</p>	W000455	The facility has developed and implemented a policy regarding safe practices to ensure prevention, control, and investigation of infection, communicable disease and cross contamination. The Home Manager will train the staff to ensure clients wash their hands prior to eating a meal, after using the restroom and whenever needed to ensure proper hygiene. The training will include ensuring hygiene paper supplies and soap are available to clients and staff for use at all time. In the future, the Home Manager will complete an active treatment observation 3 times for 4 weeks and then routinely twice a week to ensure the clients are encouraged to wash hands prior to dining and other disease and infectious control measures. Person Responsible: Program Director Completion Date: 3/8/15	03/08/2015			

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W000484	<p>the dining table where clients A, B, C, D, E, F and G sat to eat their meal.</p> <p>An interview with the facility's nurse was conducted on 2/6/15 at 11:45 A.M.. The nurse indicated staff should have prompted client C to wash his hands before handling the tableware, cups and plates. The nurse further indicated staff should have prompted client E to wash her hands after exiting the bathroom and before she administered medications.</p> <p>9-3-7(a)</p> <p>483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. Based on observation and interview, the facility failed for 7 of 8 clients (clients A, B, C, D, E, F and G) observed eating breakfast, to provide condiments at the dining table.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 1/30/15 from 6:15 A.M. until 8:00 A.M.. At 7:10 A.M.,</p>	W000484	<p>The facility provides each group home fully furnished with necessary domestic equipment to meet the needs of the clients. The areas of the group home are equipped with dining elements designed to meet the developmental needs of the clients. The Home Manager will train the staff to provide the clients will all dining utensils and items needed for meal enjoyment including condiments. In the future, the facility staff will offer</p>	03/08/2015			

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W000488	<p>Clients A, B, C, D, E, F and G began eating their meal which consisted of cold cereal and toasted English muffins. No sugar/sugar substitute or jelly were on the table for clients A, B, C, D, E, F and G's use.</p> <p>An interview with the Area Director (AD) was conducted on 2/6/15 at 11:45 A.M.. The AD indicated sugar/sugar substitute and jelly should be put on the table for the clients to use.</p> <p>9-3-8(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview the facility failed for 4 of 4 sampled clients (clients A, B, C and D) to ensure they assisted with meal preparation.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 1/30/15 from 6:15 A.M. until 8:00 A.M.. At 7:00 A.M., Direct Support Professional (DSP) #3 was observed putting English muffins</p>	W000488	<p>the clients all mealtime furnishings. The Home Manager will complete 3 observations weekly and then twice a week routinely to ensure the staff provide all items necessary to eat their meal while providing choices. Responsible Staff: Area Director Completion Date: 3/8/15</p> <p>The facility will ensure that each client eats in a manner consistent with his or her developmental level. Staff will be retrained in the area of redirecting at mealtime to teach meal preparation skills. In addition the training reviewed implementation of client cooking, dining goals and overall active treatment. The Home Manager will ensure that all staff are trained and will monitor mealtime activities during three times weekly and then two times</p>	03/08/2015	

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	<p>into the toaster as clients A, B and C sat in the living room with no activity. Client D sat in his room with no activity. DSP #3 then placed each toasted English muffin on a serving plate and placed the plate on the dining table. The meal consisted of cold cereal and toasted English muffins. Clients A, B, C and D did not and were not prompted to assist in toasting the English muffins.</p> <p>An interview with the Area Director (AD) was conducted on 2/6/15 at 11:45 A.M.. The AD indicated staff should have had clients A, B, C and D assist in toasting the English muffins.</p> <p>9-3-8(a)</p>		<p>routinely supervisory observations in the home to ensure active treatment outlined in the client plan. Person Responsible: Program Director</p>				