STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G793	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNGARVIN INDIANA LLC	113 S 325 E VALPARAISO, IN 46385

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	This visit was for the investigation of Complaint #IN00151484. This visit resulted in an Immediate Jeopardy. Complaint #IN00151484: Substantiated, Federal and state deficiencies related to the allegations are cited at W102, W104, W122, W149, W153, W227 and W240. Dates of Survey: June 24, 25, 26, 27, 30, July 1, 3 and 7, 2014. Facility number: 012584 Provider number: 15G793 AIM number: 201018520 Surveyor: Paula Eastmond, QIDP-TC These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/10/14 by Ruth Shackelford, QIDP.	W000000		
W000102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, interview and record review, the facility failed to meet	W000102	**W 102 483.410 GOVERNING BODY AND MANAGEMENT**	08/06/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	the Condition of Participation: Governing Body for 2 of 2 sampled clients (A and B). The governing body failed to implement its policy and procedures to prevent neglect of clients A and B, and failed to ensure an allegation of neglect was immediately reported to the administrator and/or to other state officials. Findings include: 1. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for clients A and B. The governing body failed to ensure clients A and B were not neglected in regard to a client who had a history of choking, and/or a client's elopement behavior. Please see W122. 2. The governing body failed to implement its written policy and procedures to prevent neglect of client A in regard to a choking incident. The governing body failed to ensure the facility monitored/supervised a client who had a known history of choking. The governing body failed to ensure the facility documented/reported all incidents of choking, sneaking/hiding food and to address client A's identified behavioral need to prevent a choking incident which resulted in the client's death. The		In conjunction with the Plans of Correction for W104, W122, W149, and W153, the House Manager, QDDP, Nurse, and Behaviorist will review this Condition of Participation. Dungarvin has written policies and procedures that prohibit mistreatment, neglect, or abuse of our Individuals Served. This Policy specifically states that staff are to immediately report to the Supervisor (who will in-turn immediately report to the Administrator and DDARS/BDDS) any actual or suspected abuse, neglect, or exploitation of an Individual Served. All staff have been re-trained on Dungarvin's Abuse, Neglect, and Exploitation Policy, with an emphasis on appropriate monitoring of Individual's in an ICF-ESN setting, and per their ISP and BSP Protocol. For example, if two individuals are on one side of the house and another is in their bedroom on the other side, there *must* be a staff person on the side of the house where the individual is in their bedroom. All staff have been re-trained on Dungarvin's Reporting Policy, with an emphasis on reporting anything unusual, anything that may be a health/safety concern, and if one is unsure whether or not to report it, they should report it. Per Policy, once reported to the Supervisor, the Supervisor will then report to the Administrator and DDARS/BDDS. All staff have been re-trained on all Individuals' ISPs and Risk Plans. All staff have been	

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	governing body failed to implement its written policy and procedures to prevent neglect of client B in regard to the client's elopement behavior. The governing body failed to ensure the facility staff immediately reported an allegation of possible neglect (choking incident) immediately to the administrator and/or to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b)(5) and to Adult Protective Services (APS) per IC 12-10-3 for client A. Please see W104. This federal tag relates to complaint #IN00151484. 9-3-1(a)		re-trained on all Individuals' protocol in regards to periodic checks during private time, room sweeps, or any other checks according to their ISP and/or BSP. All staff have been re-trained on documentation needing to be completed according to the Individual's ISP, BSP, Risk Plans, and Dungarvin Policy. All staff have been trained on emergency protocol, with an emphasis on the plan to continue to monitor the other individuals in the event of an emergency where staff resources are concentrated on one or two of the individuals, including calling Q/House Manager for additional, immediate staff supports if necessary. QDDP interviewed staff and Individuals have been interviewed in regards to their identified needs and risks. All newly identified needs and/or risks have been presented to the IDT s and safe-guards put in their ISPs and/or Risk plans, and all staff have been trained on these revised ISPs and/or risk plans. QDDP reviewed all assessments to ensure all risks and needs identified have been addressed with the Individual's IDT and put in their ISP and/or risk plan. All staff have been trained on these revised ISPs and/or risk plans. House Manager, QDDP, and Nurse reviewed all of last 3 months of documentation, paying strict attention to trends, identified possible health/safety issues, needed	

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			risk plans, needed staff training, behavior trends, etc. All identified trends have been reviewed by AD and individual's IDT, and addressed through the Individual's ISP, BSP, and/or risk plans. All staff have been trained on these revised ISPs and/or risk plans. QDDP or House Manager have maintained daily contact/conversation with staff, including asking if there are any issues or incidents that need to be reported to the supervisor. Beginning 6/26/14 and continuing through 7/26/14, and then every week thereafter if in compliance, Q and/or House manager have been reviewing all documentation daily and all identified risks, trends, health and safety issues have been presented/ addressed promptly by the Individual's IDT, put in their ISP, BSP, and/or risk plans, and all staff have been trained on the revised plans. Any staff responsible for not following Policy/Procedure in regards to reporting significant issues have received disciplinary action. Notes of these documentation reviews have been forwarded to the Area Director. Beginning 6/26/14 and continuing through 7/26/14 then every week thereafter if in compliance, QDDP, House Manager, Nurse, and/or Behaviorist have been conducting observations to ensure staff are following the Individual's plans and following policy/procedures. **Will be completed by: 8/6/14**	

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			Persons Responsible: Area Director, House Manager, Nurse, Behaviorist, and QDDP	
W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 2 of 2 sampled clients (A and B), the governing body failed to exercise general policy and operating direction over the facility to ensure the facility did not neglect clients A and B. The governing body failed to exercise general policy and operating direction over the facility ensure the facility implemented its policy and procedures to prevent neglect of clients A and B, and to ensure an allegation of neglect was immediately reported to the administrator and/or to other state officials. Findings include: 1. The governing body failed to exercise general policy and operating direction over the facility to implement its written policy and procedures to prevent neglect of client A in regard to a choking incident. The governing body failed to exercise general policy and operating direction over the facility to monitor/supervise a client who had a known history of choking. The	W000104	**W 104 483.410(a)(1)** **GOVERNING BODY** In conjunction with the Plans of Correction for W102, W122, W149, and W153, the House Manager, QDDP, Nurse, and Behaviorist will review this Condition of Participation. Dungarvin has written policies and procedures that prohibit mistreatment, neglect, or abuse of our Individuals Served. This Policy specifically states that staff are to immediately report to the Supervisor (who will in-turn immediately report to the Administrator and DDARS/BDDS) any actual or suspected abuse, neglect, or exploitation of an Individual Served. All staff have been re-trained on Dungarvin's Abuse, Neglect, and Exploitation Policy, with an emphasis on appropriate monitoring of Individual's in an ICF-ESN setting, and per their ISP and BSP Protocol. For example, if two individuals are on one side of the house and another is in their bedroom on the other side, there *must* be a staff person on the side of the house where the individual is in their bedroom. All staff have been	08/06/2014

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	governing body failed to exercise general policy and operating direction over the facility to document/report all incidents of choking, sneaking/hiding food and to address client A's identified behavioral need to prevent a choking incident which resulted in the client's death. The governing body failed to exercise general policy and operating direction over the facility to implement its written policy and procedures to prevent neglect of client B in regard to the client's elopement behavior. Please see W149. 2. The governing body failed to exercise general policy and operating direction over the facility to ensure facility staff immediately reported an allegation of possible neglect (choking incident) to the administrator and/or to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b)(5) and to Adult Protective Services (APS) per IC 12-10-3 for client A. Please see W153. This federal tag relates to complaint #IN00151484. 9-3-1(a)		re-trained on Dungarvin's Reporting Policy, with an emphasis on reporting anything unusual, anything that may be a health/safety concern, and if one is unsure whether or not to report it, they should report it. Per Policy, once reported to the Supervisor, the Supervisor will then report to the Administrator and DDARS/BDDS. All staff have been re-trained on all Individuals' ISPs and Risk Plans. All staff have been re-trained on all Individuals' protocol in regards to periodic checks during private time, room sweeps, or any other checks according to their ISP and/or BSP. All staff have been re-trained on documentation needing to be completed according to the Individual's ISP, BSP, Risk Plans, and Dungarvin Policy. All staff have been trained on emergency protocol, with an emphasis on the plan to continue to monitor the other individuals in the event of an emergency where staff resources are concentrated on one or two of the individuals, including calling Q/House Manager for additional, immediate staff supports if necessary. QDDP interviewed staff and Individuals have been interviewed in regards to their identified needs and risks. All newly identified needs and/or risks have been presented to the IDT s and safe-guards put in their ISPs and/or Risk plans, and all staff have been trained on these revised	

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			ISPs and/or risk plans. QDDP reviewed all assessments to ensure all risks and needs identified have been addressed with the Individual's IDT and put in their ISP and/or risk plan. All staff have been trained on these revised ISPs and/or risk plans. House Manager, QDDP, and Nurse reviewed all of last 3 months of documentation, paying strict attention to trends, identified possible health/safety issues, needed risk plans, needed staff training, behavior trends, etc. All identified trends have been reviewed by AD and individual's IDT, and addressed through the Individual's ISP, BSP, and/or risk plans. All staff have been trained on these revised ISPs and/or risk plans. QDDP or House Manager have maintained daily contact/conversation with staff, including asking if there are any issues or incidents that need to be reported to the supervisor. Beginning 6/26/14 and continuing through 7/26/14, and then every week thereafter if in compliance, Q and/or House manager have been reviewing all documentation daily and all identified risks, trends, health and safety issues have been presented/ addressed promptly by the Individual's IDT, put in their ISP, BSP, and/or risk plans, and all staff have been trained on the revised plans. Any staff responsible for not following Policy/Procedure in regards to reporting significant issues have received disciplinary action. Notes of these documentation	

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			reviews have been forwarded to the Area Director. Beginning 6/26/14 and continuing through 7/26/14 then every week thereafter if in compliance, QDDP, House Manager, Nurse, and/or Behaviorist have been conducting observations to ensure staff are following the Individual's plans and following policy/procedures. **Will be completed by: 8/6/14** **Persons Responsible: Area Director, House Manager, Nurse, Behaviorist, and QDDP**	
W000122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 2 of 2 sampled clients (A and B). The facility neglected to implement its policy and procedures to prevent neglect of client A in regard to a choking incident which resulted in the death of the client. This non-compliance resulted in an Immediate Jeopardy as the facility neglected to ensure the client with a known risk for choking was monitored/supervised to prevent taking of food to hide and eat without staff supervision. The Immediate Jeopardy was identified on 6/25/14 at 10:23 PM. The Area Director was notified of the	W000122	**W 122 483.420 CLIENT PROTECTIONS** In conjunction with the Plans of Correction for W102, W104, W149, and W153, the House Manager, QDDP, Nurse, and Behaviorist will review this Condition of Participation. Dungarvin has written policies and procedures that prohibit mistreatment, neglect, or abuse of our Individuals Served. This Policy specifically states that staff are to immediately report to the Supervisor (who will in-turn immediately report to the Administrator and DDARS/BDDS) any actual or suspected abuse, neglect, or exploitation of an Individual Served. All staff have been re-trained on Dungarvin's Abuse, Neglect, and	08/06/2014

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	Immediate Jeopardy on 6/26/14 at 11:26 AM. The Immediate Jeopardy began on 6/22/14. The facility submitted a plan of removal of the Immediate Jeopardy on 6/30/14 at 10:02 AM. The Immediate Jeopardy was removed on 7/3/14 at 12:00 PM through observation, interview and record review. It was determined the facility implemented a plan of action to remove the Immediate Jeopardy, and the steps taken removed the immediacy of the problem. During the 6/27/14 observation period between 12:20 PM and 1:15 PM, at the group home, there were 2 staff at the group home with client D. Client D was eating his lunch while both staff were at the dining room table. Client D ate his lunch without incident. During the 7/3/14 observation period between 10:37 AM and 11:25 AM, there were 3 staff to 3 clients (B, C and D) at the group home. Staff #14 watched/monitored client B while he ate his breakfast and kept client B in line of sight. During the above mentioned observation period, staff followed client D when he went back to his bedroom. Interview with staff #11 on 7/3/14 at 11:00 AM stated staff #11 had been		Exploitation Policy, with an emphasis on appropriate monitoring of Individual's in an ICF-ESN setting, and per their ISP and BSP Protocol. For example, if two individuals are on one side of the house and another is in their bedroom on the other side, there *must* be a staff person on the side of the house where the individual is in their bedroom. All staff have been re-trained on Dungarvin's Reporting Policy, with an emphasis on reporting anything unusual, anything that may be a health/safety concern, and if one is unsure whether or not to report it, they should report it. Per Policy, once reported to the Supervisor, the Supervisor will then report to the Administrator and DDARS/BDDS. All staff have been re-trained on all Individuals' ISPs and Risk Plans. All staff have been re-trained on all Individuals' protocol in regards to periodic checks during private time, room sweeps, or any other checks according to their ISP and/or BSP. All staff have been re-trained on documentation needing to be completed according to the Individual's ISP, BSP, Risk Plans, and Dungarvin Policy. All staff have been trained on emergency protocol, with an emphasis on the plan to continue to monitor the other individuals in the event of an emergency where staff resources are concentrated on one or two of the individuals, including calling Q/House Manager for additional,	

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	retrained in regards to the clients' diets, Individual Support Plans (ISPs), Behavior Support Plans (BSPs), reporting policies and documentation of data in the "last 3 days." Staff #11 indicated she had been trained in regard to the facility's Emergency Protocol. Interview with staff #8 on 7/3/14 at 11:05 AM indicated staff #8 had been retrained in regards to the clients' diets, Individual Support Plans (ISPs), Behavior Support Plans (BSPs), reporting policies and documentation of data "this week." Staff #8 indicated she had been trained in regard to the facility's Emergency Protocol. Interview with staff 14 on 7/3/14 at 11:10 AM indicated staff #14 had been retrained in regards to the clients' diets, Individual Support Plans (ISPs), Behavior Support Plans (BSPs), reporting policies and documentation of data "yesterday." Staff #14 indicated he was a new hire and went through training and was then retrained with the behavioral therapist and nurse. Staff #14 indicated he had been trained in regard to the facility's Emergency Protocol. Interview with the QIDP on 7/3/14 at 11:40 AM indicated she was going to the group home to monitor and calling the		immediate staff supports if necessary. QDDP interviewed staff and Individuals have been interviewed in regards to their identified needs and risks. All newly identified needs and/or risks have been presented to the IDT s and safe-guards put in their ISPs and/or Risk plans, and all staff have been trained on these revised ISPs and/or risk plans. QDDP reviewed all assessments to ensure all risks and needs identified have been addressed with the Individual's IDT and put in their ISP and/or risk plan. All staff have been trained on these revised ISPs and/or risk plans. House Manager, QDDP, and Nurse reviewed all of last 3 months of documentation, paying strict attention to trends, identified possible health/safety issues, needed risk plans, needed staff training, behavior trends, etc. All identified trends have been reviewed by AD and individual's IDT, and addressed through the Individual's ISP, BSP, and/or risk plans. All staff have been trained on these revised ISPs and/or risk plans. QDDP or House Manager have maintained daily contact/conversation with staff, including asking if there are any issues or incidents that need to be reported to the supervisor. Beginning 6/26/14 and continuing through 7/26/14, and then every week thereafter if in compliance, Q and/or House manager have been reviewing all documentation daily	

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	group home at different times of the day. The QIDP indicated facility staff had been retrained on reporting, documentation, clients' ISPs and BSPs, diets and health issues. The facility's inservice training records were reviewed on 7/3/14 at 11:40 AM. The 6/30/14 Statement Of In-Service Training For Employees indicated the QIDP conducted training on "Reporting policy, Abuse, Neglect and Exploitation policy, Room sweeps, Emergency Protocols/Appropriate monitoring of Individuals" on 6/30/14. Review of the 6/30/14 and 7/1/14 employee signed inservice records indicated all facility staff had been retrained. The facility's 7/1/14 inservice records indicated all facility staff were retrained on clients B, C and D's ISPs, BSPs and Health Risks by the QIDP, the Behavior Specialist and the nurse. The inservice training included training in regard to the clients' diets, nutrition and swallowing difficulties, goals, behavior plans, "significant health concerns," adaptive equipment, supervision requirements, risk plans and client rights and dignity. The facility's Call Log and Site Visit notes were reviewed on 7/3/14 at 11:50		and all identified risks, trends, health and safety issues have been presented/ addressed promptly by the Individual's IDT, put in their ISP, BSP, and/or risk plans, and all staff have been trained on the revised plans. Any staff responsible for not following Policy/Procedure in regards to reporting significant issues have received disciplinary action. Notes of these documentation reviews have been forwarded to the Area Director. Beginning 6/26/14 and continuing through 7/26/14 then every week thereafter if in compliance, QDDP, House Manager, Nurse, and/or Behaviorist have been conducting observations to ensure staff are following the Individual's plans and following policy/procedures. **Will be completed by: 8/6/14** **Persons Responsible: Area Director, House Manager, Nurse, Behaviorist, and QDDP**	

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	AM. The notes indicated the QIDP monitored the site on 6/27/14 at 1:00 PM, 7/1/14 at 4:30 PM and on 7/2/14 at 12:00 PM. The notes indicated the QIDP called the group home to speak with staff on any concerns on 6/28, 6/29, 6/30, 7/1 and 7/2/14. The QIDP notes indicated there were no concerns and/or incidents reported to the QIDP. While the Immediate Jeopardy was removed on 7/3/14, the facility remained out of compliance at the Condition level of Client Protections in that the facility needed to finish implementing its plan of removal to ensure it was effective and met the needs of the clients. Findings include: 1. The facility failed to implement its written policy and procedures to prevent neglect of client A in regard to a choking incident. The facility failed to monitor/supervise a client who had a known history of choking. The facility failed to document/report all incidents of choking, sneaking/hiding food and to address client A's identified behavioral need to prevent a choking incident which resulted in the client's death. The facility failed to implement its written policy and procedures to prevent neglect of client B in regard to the client's elopement			

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	behavior. Please see W149. 2. The facility failed to ensure facility staff immediately reported an allegation of possible neglect (choking incident) to the administrator and/or to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b)(5) and to Adult Protective Services (APS) per IC 12-10-3 for client A. Please see W153. This federal tag relates to complaint #IN00151484. 9-3-2(a)			
W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, interview and record review for 2 of 2 sampled clients (A and B), the facility neglected to implement its written policy and procedures to prevent neglect of client A in regard to a choking incident. The facility neglected to monitor/supervise a client who had a known history of choking. The facility neglected to document/report all incidents of choking, sneaking/hiding food and to address	W000149	**W 149 483.420(d)(1) STAFF TREATMENT OF CLIENTS** In conjunction with the Plans of Correction for W102, W104, W122, and W153, the House Manager, QDDP, Nurse, and Behaviorist will review this Condition of Participation. Dungarvin has written policies and procedures that prohibit mistreatment, neglect, or abuse of our Individuals Served. This Policy specifically states that staff are to immediately report to the Supervisor	08/06/2014

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	client A's identified behavioral need to prevent a choking incident which resulted in the client's death. The facility neglected to implement its written policy and procedures to prevent neglect of client B in regard to the client's elopement behavior. Findings include: 1. The facility's reportable incident reports and/or investigations were reviewed on 6/24/14 at 2:05 PM. The facility's reportable incident reports and/or investigations indicated the following: -1/13/14 "On 01/13/2014 at 12:35PM [client A] sat down to eat lunch which consisted of sloppy joe on a bun and french fries. After taking just a few bites of food [client A] got up from the table and started walking to the kitchen. Staff (staff #2 and staff #3) asked [client A] are you ok, do you need help? [Client A] did not respond but staff (staff #2 and) (sic) saw that he was having a hard time breathing and still was not responding to staff. So staff (staff #2)did (sic) the Heimlich maneuver on [client A]. [Client A] had choked on a piece of bread which came up after the Heimlich was administered. [Client A] threw up twice afterwards. Staff then gave [client A]		(who will in-turn immediately report to the Administrator and DDARS/BDDS) any actual or suspected abuse, neglect, or exploitation of an Individual Served. All staff have been re-trained on Dungarvin's Abuse, Neglect, and Exploitation Policy, with an emphasis on appropriate monitoring of Individual's in an ICF-ESN setting, and per their ISP and BSP Protocol. For example, if two individuals are on one side of the house and another is in their bedroom on the other side, there *must* be a staff person on the side of the house where the individual is in their bedroom. All staff have been re-trained on Dungarvin's Reporting Policy, with an emphasis on reporting anything unusual, anything that may be a health/safety concern, and if one is unsure whether or not to report it, they should report it. Per Policy, once reported to the Supervisor, the Supervisor will then report to the Administrator and DDARS/BDDS. All staff have been re-trained on all Individuals' ISPs and Risk Plans. All staff have been re-trained on all Individuals' protocol in regards to periodic checks during private time, room sweeps, or any other checks according to their ISP and/or BSP. All staff have been re-trained on documentation needing to be completed according to the Individual's ISP, BSP, Risk Plans, and Dungarvin Policy. All staff have been trained on emergency	

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	some water and called the nurse (Registered Nurse-RN #1) to inform her about what occurred. The nurse made an appointment for [client A] to see the doctor the same day. At the doctor appointment the doctor said he seemed fine but requested he have some test (X-RAY) and upper GI (gastrointestinal)one (sic). These tests have been scheduled to be done this week. [Client A] has shown no other signs of having trouble breathing. [Client A's] food will be cut up into small sections to reduce the possibility of this happening in the future." The facility's 1/31/14 follow-up report indicated client A had a previous choking plan in place prior to the 1/13/14 choking incident. The follow-up report indicated "...At that time-all meats were to be cut up into small pieces. 4. (numbers are as listed in report) No previous choking while in our care, however, there were frequent choking events in the past at mom's home. 6. His diet is stated as 'Texture Restricted' due to his likes/dislikes of food - he prefers not to eat anything hard. He is not on a pureed/chopped/thicken liquids type of diet. 11. Staff will continue to monitor [client A] while eating. All of his food will be cut into 1 inch (or less) bites - not just meats - all food. 12. Yes, he will		protocol, with an emphasis on the plan to continue to monitor the other individuals in the event of an emergency where staff resources are concentrated on one or two of the individuals, including calling Q/House Manager for additional, immediate staff supports if necessary. QDDP interviewed staff and Individuals have been interviewed in regards to their identified needs and risks. All newly identified needs and/or risks have been presented to the IDT s and safe-guards put in their ISPs and/or Risk plans, and all staff have been trained on these revised ISPs and/or risk plans. QDDP reviewed all assessments to ensure all risks and needs identified have been addressed with the Individual's IDT and put in their ISP and/or risk plan. All staff have been trained on these revised ISPs and/or risk plans. House Manager, QDDP, and Nurse reviewed all of last 3 months of documentation, paying strict attention to trends, identified possible health/safety issues, needed risk plans, needed staff training, behavior trends, etc. All identified trends have been reviewed by AD and individual's IDT, and addressed through the Individual's ISP, BSP, and/or risk plans. All staff have been trained on these revised ISPs and/or risk plans. QDDP or House Manager have maintained daily contact/conversation with staff, including asking if there are any	

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	stuff multiple bites of food into his mouth without chewing and swallowing. He will eat and drink rapidly and at an unsafe pace. He will attempt to take too big of bites as well...27. He had a swallow study ordered and it has been completed. Recommendations were for thickened liquids...." The 1/31/14 follow-up report also indicated client A had a choking risk plan dated 12/2/13 "To prevent choking and aspiration while eating...." The facility's 2/5/14 follow-up report indicated facility staff would sit with client A while he ate to assist the client not to eat fast and/or stuff his mouth. The follow-up report indicated "...He will also be giving (sic) small serving sizes to try and decrease his efforts to eat food fast/stuffing his mouth...." -6/22/14 "On 6/22/2014 at 10:20 PM [client A] had just finished cleaning his room and making up his bed. Staff then left to go into the office to start doing paperwork. Another staff went into his room to do a fifteen minute check on him. That staff saw [client A] lying down on his bed resting. Five minutes later [client A] came out of his bedroom running into the common area front (sic) choking. Staff immediately started doing the Heimlich maneuver but nothing came		issues or incidents that need to be reported to the supervisor. Beginning 6/26/14 and continuing through 7/26/14, and then every week thereafter if in compliance, Q and/or House manager have been reviewing all documentation daily and all identified risks, trends, health and safety issues have been presented/ addressed promptly by the Individual's IDT, put in their ISP, BSP, and/or risk plans, and all staff have been trained on the revised plans. Any staff responsible for not following Policy/Procedure in regards to reporting significant issues have received disciplinary action. Notes of these documentation reviews have been forwarded to the Area Director. Beginning 6/26/14 and continuing through 7/26/14 then every week thereafter if in compliance, QDDP, House Manager, Nurse, and/or Behaviorist have been conducting observations to ensure staff are following the Individual's plans and following policy/procedures. **Will be completed by: 8/6/14** **Persons Responsible: Area Director, House Manager, Nurse, Behaviorist, and QDDP**	

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	up. Another staff also did the Heimlich on [client A] but [client A] began to panic and pushed staff back to get away from staff. [Client A] walked away from staff and fell on the floor face forward. One staff immediately turned him over, checked [client A's] mouth for food and in the process [client A] bit down on staff's index finger. Staff started CPR (Cardiopulmonary Resuscitation) (sic) another called 911. Staff (staff #3 and #4) took turns administering CPR. [Client A] attempted to get up but fall (sic) back down again. Staff started CPR (staff #3 and #4 still alternating and performing CPR) again, being walked through it by 911 operator. Twenty minutes later the paramedics arrived and at first watched staff doing CPR. Another staff asked them if they were going to take over or try to help and the medic stated yes. The EMT (Emergency Medical Technician) then slowly got on the floor and started administering CPR. The fire department, police officers and more paramedics arrived. The medics asked staff if they tried to get any food out of his mouth and staff stated that yes she checked for food but that he bit down on her finger and to please check again. Medics continued CPR and finally used a Medical tool to pull clumped up taco bread out of his mouth. The paramedics then put him on oxygen and attached a			

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	machine to his chest before taking [client A] to the hospital. The QDDP (Qualified Developmental Disabilities Professional) and nurse was (sic) notified. The QDDP requested a room sweep be done to see if any food was found in his room and none was found. The nurse then met staff at the hospital to see how [client A] was doing. An hour after being there the hospital staff then came out to ask staff and the nurse what happened. After explaining everything to the hospital staff, hospital staff left but came back twenty minutes later and informed the nurse and staff that [client A] passed away...Staff will continue protocols with practicing CPR and calling 911 for incidents such as this. We will review all risk plans for our other individuals and will do an internal investigation for the events leading up to this...." The 6/22/14 incident report indicated client A died on 6/23/14 at "00:10:00" (12:10 AM). The follow-up report indicated the preliminary cause of death was "Unknown." During the 6/24/14 observation period between 4:20 PM and 7:40 PM, at the group home, client A's bedroom was located in the back hallway across from the back living room area. The kitchen's entrance and pantry area were in the back hallway leading to client A's bedroom.			

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	The group home's office and main living room were located at the front of the group home with no view of the back hallway, back bathroom, 2 back bedrooms and/or pantry areas. The facility's staff communication book was reviewed on 6/24/14 at 7:10 PM. A 4/1/14 note indicated "[Client A] had a choking episode @ (at) the dinner table with his Veggies. Staff assisted him and he was ok, no more problems with [client A], he said he know what to do (sic)." Confidential interview Z indicated client A had an incident where the client choked at a dinner meal eating broccoli. Confidential interview Z stated "Staff gave Heimlich and he (client A) spit it out." Confidential interview Z indicated the choking occurred in April 2014. Confidential interview Z indicated the broccoli was cut into 1 inch pieces when the client choked. The facility's reportable incident reports and/or investigations since 1/14, indicated the facility staff neglected to report client A's 4/1/14 choking incident to the facility's administrator and nurse. Client A's hospital records were reviewed on 6/25/14 at 11:59 AM. Client A's 6/22/14 Emergency Department (ED)			

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	Triage note indicated "Per EMS (Emergency Medical Services) pt (patient) at group home, witnessed choking episode, and pt collapsed and was asystole (cardiac flat line) when EMS arrived at home. Upon arrival to ER pt intubated...." Client A's 6/22/14 Emergency Documentation note indicated "The patient presented to the emergency department in cardiac arrest by EMS. The patient reportedly choked on food at his group home. The paramedics note that they used McGill forceps to remove a large portion of food from the patient's upper airway. Patient was intubated in the field and CPR was initiated. They note the patient received 2 rounds of epinephrine through the ET (Endotracheal Tube) tube and 4 rounds of epinephrine by IV (intravenous). The patient has remained pulseless since the time of the cardiac arrest. The patient was worked on the scene for approximately 20 minutes with a 10 minute transit time to the emergency department. Patient presented 30 minutes after cardiac arrest...." The note indicated "...Swelling of the subcutaneous tissue was noted bilaterally on the anterior neck...." Client A's 6/22/14 Emergency Documentation note indicated client A was "unresponsive"			

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	when he arrived at the ER. The note indicated "Pt arrived per [name of city] Fire EMS to this ER at 2316 (11:16 PM), pt unresponsive, no pulse, and ventilations assisted. CPR in progress, pt intubated in field per EMS. [Name of doctor], respiratory and ER staff continued CPR, pt in PEA (pulseless electrical activity). JVD (Jugular Venous Pressure) noticeable...Pt never regained a pulse, per [name of doctor] verbal order at bedside 2328 (11:28 PM) CPR ceased and pt time of death 2328." The Emergency Documentation note indicated client A's diagnosis included, but not limited to, Cardiac Arrest. Client A's record was reviewed on 6/25/14 at 1:51 PM. Client A's 1/13/14 Medical Visit Summary form indicated client A went to see his doctor as he "choke on food." The form indicated client A's doctor ordered an Upper GI swallow and a chest X-ray to be done. The 1/13/14 form indicated "One-on-one monitoring for portion sizes at all meals & (and) snacks." Client A's 1/29/14 Medical Visit Summary form indicated a cookie swallow was completed. The 1/29/14 form indicated "Diet Rec (recommended): Nectar Thick Liquid/Regular solids			

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	-Penetration of thin liquid to the vocal cords." Client A's 2/6/14 order request indicated client A's diet was changed to "Nectar-thick liquids with regular solids" on 2/6/14. Client A's 5/30/14 Dietician Progress Note indicated client A was on a regular diet with food cut into 1 inch pieces with nectar thick liquids. The 5/30/14 note indicated "...Provide snacks/second helpings if he is still hungry." Client A's January 2014 monthly nursing note indicated "...Monitor for signs/symptoms of Choking: One episode reported-no complications from incident...." Client A's February, March, April and May 2014 monthly nursing summaries indicated "...Monitor for signs/symptoms of Choking: None reported...." Client A's monthly nursing summaries indicated facility staff neglected to report the 4/1/14 choking incident to the nurse. Client A's 6/22/14 Q (every) 15 Monitor Form (routine monitoring of clients) indicated facility staff last checked/monitored client A at 10:00 PM. The form indicated client A was in his bedroom. Client A's June 2014 Sleep			

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	Chart indicated client A was asleep at 10:00 PM and 11:00 PM on 6/22/14. Client A's X/O Charts from 1/14 to 6/14 indicated an area for "Choking" and "Aspiration Pneumonia." Client A's 4/14 X/O chart indicated the facility staff neglected to document client A's 4/1/14 choking incident. Client A's X/O charts did not indicate any additional incident of choking except for on 1/13/14 and 6/22/14. No incidents of Aspiration were indicated from 1/14 to 6/14. Client A's ABC Checklist (documentation of behaviors) indicated the following (not all inclusive): -2/3/14 "At approximately 1:30am [client A] came out saying he was hungry and was trying to break into other individuals (sic) rooms...." The checklist indicated client A was trying to get to another client's cup. -6/15/14 "[Client A] was in the kitchen getting a drink of water. [Client A] took anothers (sic) housemate's food and placed the plate underneath the bathroom sink...." Client A's Daily Record of Residential Habilitation Services rendered indicated the following (not all inclusive):			

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	-6/8/14 Client A's note indicated client A had a toileting accident in his bed and while staff was mopping the floor, staff "...found 3 plates (empty), banana peels all under his bed and a big bottle of barbeque sauce (empty) all under his bed, and 5 cups in his room. Please staff checked (sic) on [client A] more often. No problems out of [client A] at this time." -6/15/14 "[Client A] woke up when staff arrived, took meds then a shower. He then ate breakfast with other housemates. [Client A] then hid breakfast food that was for another housemate under bathroom sink cabinet half eaten...." -6/18/14 "...Staff reminded him to eat his food slowly...." Client A's ABC checklists and/or daily notes neglected to indicate additional documentation in regard to the client's choking on food and/or hiding/taking food. Client A's record ABC checklists and/or daily notes indicated the facility neglected to document/track all incidents of taking/hiding food. Client A's 5/15/14 Behavioral Support Plan (BSP) indicated client A demonstrated the target behaviors of physical aggression, verbal aggression			

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	and property destruction. Client A's 12/2/13 Health Risk: Choking Plan indicated client A was at risk for choking. The plan indicated "Choking related to food texture difficulties and inability to pace self while eating/drinking. Goal: To prevent choking and aspiration while eating...." The plan indicated client A was to have "Closer supervision during eating and/or taking medication...." The plan indicated client A's food was to be cut into bite size pieces. Client A's 2/11/14 Health Risk: Risk for Aspiration Pneumonia plan indicated "...Aspiration Pneumonia secondary to risk for choking...." Client A's record and/or 1/9/14 Individual Support Plan (ISP) indicated the client's IDT (interdisciplinary team) neglected to meet/document its meeting, review and/or update client A's choking risk plan after the 1/13/14 choking incident. Client A's above mentioned risk plans, ISP and/or behavior plan neglected to indicate specifically how facility staff were to monitor/supervise client A to prevent the client from eating food without staff's supervision. Client A's ISP and/or BSP neglected to indicate how client A's room and/or others areas of the			

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	house were to be monitored to prevent client A from hiding/consuming food without staff's knowledge/supervision. Client A's ISP and/or 5/15/14 BSP indicated the facility neglected to address client A's identified behavioral need in regard to taking/hiding food to prevent the client from choking. Confidential interview Z indicated client A was at risk for choking. Confidential interview Z indicated facility staff monitored client A at snacks and meal times. Confidential interview Z indicated client A received a regular diet with food cut up into 1 inch pieces with the client's liquids thickened. Confidential interview Z indicated 3 staff were on duty at the time of the choking incident. Confidential interview Z stated "He choked on bread. I don't remember seeing taco bread in the refrigerator." Confidential interview Z indicated she was trained in CPR. Confidential interview Z indicated facility staff were to monitor all clients in the home every 15 minutes and document the checks. Confidential interview Z stated "15 minute checks are normal. If he (client A) goes into the kitchen, be behind him." Confidential interview Z stated client A "would take food and hide it." Confidential interview Z stated at one time, "a whole pot" was found under the			

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	bathroom sink. Confidential interview Z stated "Apparently took (pot) off stove. Found when midnight shift came on and did sweep." Confidential interview Z stated client A's mother used to keep a "chain and pad lock" on the refrigerator at her house to keep the client from getting to food. Confidential interview Z indicated client A would try to take food out of the kitchen and would hide the food in different areas of the house. Confidential interview Z indicated client A's bedroom was located at the back of the house. Confidential interview Z stated "Kitchen and pantry blind spot." Confidential interview Z indicated facility staff would not be able to see those areas if staff were on the front side of the house. Confidential interview Y indicated they would cut client A's food up into small pieces. Confidential interview Y stated "[Client A] likes to eat." Confidential interview Y indicated client A would eat slowly at meals. When asked how client A was monitored to prevent choking, confidential interview Y stated "We are always around him. Check on him every 5 to 10 minutes." Confidential interview W indicated client A choked on 6/22/14. Confidential interview W indicated client A was			

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	allowed to have bread. Confidential interview W stated taco bread was "flour tortilla." Confidential interview W "Staff need to be there when he (client A) ate." Confidential interview W indicated client A was a choking risk and had choked in the past. Confidential interview W stated client A would stay in his room but when he came out staff was to "watch him and go see what he was doing." Confidential interview W indicated client A would try to go into the kitchen to get food. Confidential interview W also indicated client A would hide food to consume. Confidential interview T indicated she was working the night client A choked. Confidential interview T stated "He choked. [Staff #3] started Heimlich. Nothing came up. I started Heimlich. Nothing happened. I went to call 911 and they told me not to hang up." Confidential interview T indicated client A would get up and try to get away from staff. Confidential interview T stated client A "came from around corner and went down over couch." When asked how staff knew client A was choking, confidential interview T stated "He was making a choking sound." Confidential T indicated she did not see client A take any food on 6/22/14. Confidential interview T indicated client A fell down near the dining room area and staff did			

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	the Heimlich again, and the client got up and ran into the kitchen. Confidential interview T stated client A "went down in the kitchen" and CPR was initiated. Confidential interview T indicated facility staff did a finger sweep but they were not able to get any food out of the client's mouth. When asked where staff were before client A came into the living room/front common area, confidential interview A indicated all 3 staff were in the office area. Confidential interview T stated she was doing "paper work. I'm not sure what the other staff were doing." Confidential interview T indicated client B was in the living room when client A came into the common area choking. Confidential interview T indicated client A had ribs and broccoli for dinner. Confidential interview T indicated they did not know where client A got the taco bread from. When asked if client A would hide food, confidential staff T stated "Sometimes." Confidential interview T indicated facility staff were to monitor the client when eating. When asked if client A had a behavior plan for getting food and hiding it, confidential interview T stated "Yeah, I think so." Confidential interview S stated client A "made sounds of choking." Confidential interview S indicated client A came out of his bedroom. Confidential interview S			

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	stated "gave heimlich and back thrusts." Nothing came up. [Staff #8] stepped in and said do Heimlich again. He pulled away from me and fell to floor." Confidential interview S stated they "tried to sweep mouth." Confidential interview S stated client A had "black saliva and white particles" in mouth. Confidential interview S stated "He got up and we asked if wanted water and he shook his head yes." Confidential interview S indicated they thought he was ok since he wanted water. Confidential interview S indicated client A and staff went into the kitchen and when staff #4 turned around to give the client a glass of water, client A turned around and started walking out of the kitchen. Confidential interview S stated client A "fell by the refrigerator." Confidential interview S indicated CPR was started as the client did not respond. Confidential interview S indicated they did not see client A get any food other than what he ate for dinner. Confidential interview S indicated confidential interview S was putting up the communication book in the office, a second staff was at the computer and staff #8 was standing by door of office when client A initially came in to the front common area. Confidential interview S indicated client B was up and the other clients (C and D) were in their bedrooms. When asked			

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	how often client A would get/sneak food, confidential interview S stated "He sneaks food a lot and write (note) in ABC." Confidential interview S stated "He always tries to sneak food." When asked if client A would hide food, confidential interview S stated "Yes. He gets creative in hiding food. We had just cleaned his room out." Confidential interview S indicated facility staff would do 15 minute checks on the client as they were to do 15 minute checks on all clients. Confidential interview S indicated taco bread would be kept in the refrigerator, but she did not see any taco bread in the refrigerator. Confidential interview S indicated client A required supervision when eating. Confidential interview V indicated client A came running out of his bedroom around 10:20 PM to the front common area. Confidential interview V stated client A was "gasping for air." Confidential interview V stated facility staff ran to him and "noticed he was choking" and began the Heimlich Maneuver. Confidential interview V stated "[Client A] was scared. Broke free from [staff #3], ran and hit floor face down. I came and tried to turn him over. He was bleeding from mouth." Confidential interview V stated client A "bit down on staff's finger. He let go."			

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	Confidential interview V indicated client A was able to break free again and asked for water. Confidential interview V stated "He got near refrigerator and fell back. Non responsive at this time." Confidential interview V indicated client A had been in his bedroom prior to the choking incident as the client was "showing off his bed (showing staff he had made his bed)." Confidential interview V indicated she did not see the client take any food on 6/22/14. Confidential interview V stated "He has stolen food before. He will hide and we will find it. Not an everyday thing he did." Confidential interview V indicated client A may have gotten the taco bread out of the freezer. Confidential interview V indicated she had found food under his bed in the past. When asked how client A was supervised/monitored, confidential interview V stated "Do 15 minute checks. He has to be watched when he eats food." Confidential interview V indicated client A was a choking risk. Interview with the Qualified Intellectual Disabilities Professional (QIDP), staff #1 and administrative staff #1 on 6/25/14 at 6:52 PM indicated client A had choked in the past (1/13/14). The QIDP and staff #1 indicated client A had past incidents of choking when he lived with his mother at home. Administrative staff #1			

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	indicated the facility was still conducting its investigation into the choking incident. Administrative staff #1, the QIDP and staff #1 indicated 3 staff worked the night client A choked. Administrative staff #1 indicated all 3 staff should not have been in the office area of the home. Administrative staff #1, staff #1 and the QIDP indicated they were not aware of any additional choking incidents other than the incidents on 1/13/14 and 6/22/14. When told of the 4/1/14 choking incident, the QIDP and staff #1 indicated the facility staff should have reported the choking incident. The QIDP #1 stated she was aware of an incident where client A "hid (cooked) rice under sink in the bathroom." When asked how client A's food stealing/sneaking was being addressed, staff #1 stated "We had an inservice Thursday of last week (6/19/14). When asked how the facility was addressing the client's food sneaking/hiding, the QIDP stated "No formal program. Came up in discussion." The QIDP and staff #1 indicated facility staff were to encourage client A to ask staff for food so the staff could assist the client in cutting the food up. The QIDP indicated in her interviews of the choking incident, a taco bread wrapper was found under the bathroom sink on a plate. Administrative staff #1 stated some "chewed" taco bread was			

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	also on the plate. Administrative staff #1 and the QIDP indicated the items were found after the 6/22/14 incident. Administrative staff #1 indicated the staff interviews indicated client A came out of his bedroom choking, but administrative staff #1 indicated it appears the client was in the bathroom and came out choking. Staff #1 indicated there had not been any concerns with client A getting up at night to look for food. Staff #1 and the QIDP indicated facility staff had been told to go through client A's bedroom to search for cups. The QIDP stated she had instructed staff to monitor client A's room and clean "every other day." The QIDP indicated the above mentioned information was not part of the client's ISP/BSP. The QIDP stated "I told staff to monitor and watch informally." The QIDP indicated client A's ISP/BSP did not address the client's identified behavioral need of sneaking/hiding food and/or indicate how client A was to be supervised/monitored to prevent choking incidents. When asked if client A's IDT met after the 1/13/14 choking incident, the QIDP stated "Yes. Added choking risk plan. Previous to that he did not have one." The QIDP indicated the IDT was done by email and phone conference. The QIDP did not provide documentation of the IDT meeting.			

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	Interview with RN #1 on 6/26/14 at 11:45 AM indicated she was called the night client A choked. When asked if she was informed of a 4/1/14 choking incident, RN #1 stated she was not aware of the choking incident. RN #1 indicated facility staff should call and report all choking incidents. When asked if RN #1 was aware of client A's sneaking/hiding food, RN #1 stated "I was not aware of him sneaking/hiding food." RN #1 indicated client A would "attempt to take his food back to his room and eat." 2. The facility's reportable incident reports were reviewed on 6/25/14 at 2:05 PM. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive): -2/24/14 "On 02/24/2014 at 12:15PM [client B], staff and all of his housemates were in the community on an out (sic) when they stopped at [name of large shopping center] to get some supplies for the house. [Client B] was in the van arguing and agitating the other individuals present calling them, names which included 'retarded,' 'black n.....,' and 'stupid.' Staff tried to verbally redirect him constantly but [client B] kept telling the other individuals he would 'kick their a...,' 'that he wasn't like them' and still continuously kept calling them			

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	names. Staff continued to verbally redirect [client B] while calming the other individuals down who were now agitated. [Client B] then said 'f...you man you can't stop me' and jumped out of the van and ran towards [name of large shopping center]. Staff maintained line of sight and caught up with him to try to calm him down at the electronics section of the store. In which [client B] said he's not going back to that place, he wants to go home to his family and that he wants to go to jail (sic). Staff told him that jail was not a good place for him and continued to redirect him to the van. [Client B] then said I'm not going back to the house and ran down the aisle. Staff lost sight of [client B] for 20 seconds as he turned a corner but regained sight of him immediately. Staff caught up with [client B] and continued to try to talk to him about his feelings and why he ran away from them. [Client B] then said because I need a pop. Staff then called the QMRP (QIDP) who talked to [client B] and got him to calm enough to get into the van to go back to the group home...." A 3/3/14 follow-up report indicated "... [Client B] does have a long history of elopement in the past. [Client B] will have staff member by him at all times when riding in the van and if for some reason he runs out of the van again (sic)			

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	staff will run and keep pace with him to make sure he is within line of sight at all times...Staff will continue to implement [client B's] current elopement plan and work with [client B] to express himself using appropriate verbal communication." -4/3/14 "On 4/03/2014 [client B] was in the common area waiting to get his night meds when he decided to go into his bedroom. Staff then went into the office to start preparing to pass [client B] his 11:00PM (sic) meds. Staff then walked back into his bedroom to tell him to come into the office for his meds when he realized that [client B] was no longer in his bedroom. Staff noticed [client B] walking down the street and staff followed [client B] to the gas station (about 2 miles from group home) down the street. At the gas station, staff saw [client B] walk inside of the gas station and staff promptly follows him inside. Staff then prompts [client B] to return to the home, [client B] then walks outs (sic) and says he's not going anywhere and started smoking a cigarette. Staff then tried to verbally redirect [client B] again to return to the home but [client B] smoked another cigarette and says he would walk home. Staff then followed [client B] home and when [client B] entered the home staff asked [client B] to			

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	remove any stolen items from his pockets. [Client B] became agitated with staff and started refusing verbal cues to calm down. [Client B] did reply with staff request and revealed that he had stolen two energy drinks and two sodas. Staff told him that the stolen items would need to be returned...." The 4/3/14 reportable incident report indicated client B became aggressive with staff resulting on the client being physically restrained. The reportable incident report indicated client B called the police and the police came to the group home and spoke with client B and then left. The facility's 4/10/14 follow-up report indicated client B had a behavior plan for elopement. The follow-up report indicated "...3. If so, was the plan followed? Plan was followed with the exception of staff not asking [client B] to wear the safety vest (used for night elopement for easy sighting) after seeing he left the home. Staff instead just followed him...The alarm on the door has been repaired. Staff has been retrained on [client B's] elopement plan...." Review of the facil ity's 4/8/14 Investigation Witness Statement by staff #9 indicated "...I had just prepared to give him (client B) his 11pm meds. I then went to his room and			

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	did not see him. Staff then called and said they saw [client B] running down the street...." The witness statement indicated staff #9 indicated staff #10 was in the home but they were in the kitchen. The witness statement indicated "...I (staff #9) jumped in the van an (sic) told the other staff that was watching him to return to the home and followed him...." The witness statement indicated client B was out of staff's sight "...Maybe five minutes but not long...." Staff #10's 5/15/14 (correct date) witness statement indicated staff #10 was in the office area with staff #9 and not in the kitchen. The witness statement indicated "...Did you hear the alarm go off? No, he told me he turned the alarm off when I questioned him about how he left and that he went out the front door. Who was he? [Client B]...." Staff #11's 5/16/14 (correct date) witness statement indicated staff #11 was on their way into work when they saw client B elope from the group home. The witness statement indicated staff #11 called staff #9 at the group home. The witness statement indicated staff #9 had realized client B was gone when staff #11 called the group home. Staff #11's witness statement indicated "They noticed he was gone already and started looking for him.			

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	[Staff #9] then drove and followed [client B]...." The witness statement indicated staff #11 then went to the group home to be with staff #10 and the other clients. -5/27/14 "[Client B] eloped from the home, staff immediately left out behind him keeping line of sight he was yelling that he was going to knock that b... out referring to the female staff both staff tried to redirect [client B] back into the home he refused several times and be gain (sic) throwing rocks and hitting staff car and company van and continued to threaten staff repeating that he was going to 'knock that b... out and shoot her '911' was called and they helped [client B] come back to the home he then told police that he was suicidal and that he wanted to go to the hospital the police thought it was best and called an ambulance to transport to [name of hospital] (sic)...." -6/16/14 "...at 11:50 PM staff gave [client B] his 12 AM medication. After taking his medicine [client B] walked toward his bedroom and staff proceeded to lock up the medication. At 11:52 staff then left out of the office to check on [client B] because he was on a five minute watch to make sure he went to his room. Staff noticed the door to the backyard slightly ajar and that the door chime had been			

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	ripped off. Staff immediately searched the house and the front yard. At 11:54 PM staff immediately saw [client B] running on the side of the road and followed him in the home van. Staff kept line of sight of [client B] and continued to try to redirect [client B] to get in the van or to start walking home. [Client B] started saying that he wanted to go to jail and refused to be redirected. Staff continued to try to verbally redirect [client B] all the way to the gas station down the street. Once at the gas station [client B] began asking people for money. Staff redirected [client B] and staff asked that no one give [client B] any money. [Client B] then started saying that he wanted to go to the hospital because he 'gets all the pop's (sic) he want there.' Staff told [client B] that the hospital is only for sick people. [Client B] then started talking about going to jail again and refused to get in the van to return home. Staff called the police to ask if they could assist in taking [client B] to the home and was told they could not. Staff notified the QDDP and the QDDP talked with [client B] about why jail or to hospital was not a good idea. Staff then gave [client B] two options to either get in the van to go home or he could walk with staff home. [Client B] then chose to get in the van to go home. Once at the home (sic) [client B] gave staff the door			

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	chime he took after it was requested of him, drunk (sic) some water and went to sleep...Staff will continue to follow [client B's] behavior support plan. [Client B] is currently being checked on every 5 minutes. Maintenance was contacted and new alarms are being put on all of the doors and will now be bolted down instead of with adhesive that was being currently used. The chair used to help him jump over the fence was removed from the back yard." -"On 6/22/2014 [client B] was asked to go to his bedroom at 10:20 PM due to an issue going on with another individual so he could be safe. Staff saw him enter his room. Ten minutes later staff checked on [client B] to see if he was in his room and confirmed he was in his room. At about 10:55 PM staff went to check on [client B] and found that he was not in his room or the home. Staff then went outside and could not find him. Staff then called the QDDP and was told to have some staff continue to look for [client B] while one staff stayed at the home to call police and be with the other individuals who were sleep (sic). The police arrived at the home to get a description of what [client B] was wearing and asked about where he normally go. The police then left the home to look for [client B]. Twenty-five minutes later the police called and told			

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	staff they found him at [name of large store] and to come pick him up. Staff arrived at [name of large store] to pick [client B] up and the QDDP asked that he emptied (sic) his pockets so that we could make sure he didn't have any knives on him due to his history of stealing pocket knives from stores. [Client B] became upset and in front of three officers started punching the QDDP in the arm and shoulder despite QDDP using approved DCI (physical intervention technique) blocking techniques before being held by the police to stop. The police then informed the QDDP that [client B] was being arrested for battery. [Client B] was taken to holding and processed on 06/23/2014. [Client B] is currently in jail and we are currently trying to bail him out. The team is having an emergency meeting tomorrow about this situation. When released from jail [client B] will have one on one (1 staff to 1 client) staffing." During the 6/24/14 observation period between 4:20 PM and 7:40 PM, at the group home, client B's bedroom was located near the back door of the group home. Alarms were heard on the front and back doors of the group home when the doors were opened. The group home's back yard was surrounded with a fence which was approximately 5 feet			

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	tall. The group home was located on a country road approximately 2 miles from the main road/highway, about a mile or a little over a mile to the large shopping center where client B was found on 6/22/14 (over 3 miles in all). The country road did not have any street lights and/or side walks. Client B's record was reviewed on 6/25/14 at 3:30 PM. Client B's ABC Checklists indicated the following (not all inclusive): -5/16/14 Client B was told by staff he could not have more tea as it was after 10:30 PM. The note indicated "...he was in the dining room one minute, next minute he went to his room and staff went to check on him and saw he snuck at (sic) to the back yard. Staff was able to redirect him to come back in the house...." -6/14/14 Client B took his 8 PM medication and indicated he wanted to return to the hospital. The note indicated client B "...Kept assisting (sic) we called (sic) the hospital and start (sic) walking down the street toward [name of store] gas station. Staff had visual on him at all time...." -6/16/14 "...[Client B] left staff office			

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	after taking his medication and walked out of the front common area exit. [Client B] eloped from the home and walked up to the [name of store] gas station and [client B] was asking strangers for money. [Client B] stated that he wanted to go to jail or the hospital but would not return to the facility." -6/18/14 "...At 12:55 am he (client B) eloped. Staff went after to watch him. Staff kept trying to redirect him before, during and after the situation....He went to the [name of store] gas station and got a soda." -6/19/14 "...Staff confronted individual about stealing and checking his pockets. Individual then ran away stating he was going to [name of store] gas station. Staff began to follow individual as he eloped...." Client B's Daily Record of Residential Habilitation Services rendered indicated the following (not all inclusive): -6/16/14 At 11:00PM, client B eloped "...from the front common area side door...Spotted him walking down the street; pursued the individual, [client B] walked to the [name of store] gas station followed by staff...."			

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	-6/17/14 note indicated client B was on 5 minute checks. -6/19/14 Client B was seen coming out of client D's bedroom. The note indicated when staff approached him, client B "...took off running and staff followed. He then eloped and staff maintained line of sight. He ended up at [name of store]. He then finally got in van and came home. Once home he was returned to store to pay for stolen items...." -6/23/14 "When staff arrived we were told the (sic) [client B] had eloped and staff was looking for him. The police called and informed us that he was at [name of large department store] at 1:20 AM. When staff got there police took him to jail." Client B's Monitor Forms indicated the facility was conducting 15 minute checks (routine checks) on client B. Client B's monitor forms indicated client B was on 5 minute checks on 6/5, 6/6, 6/7, and went back to routine 15 minute checks on 6/8/14. The monitor forms indicated client B was placed back on 5 minute checks on 6/16 through 6/19/14. Client B's 1/31/14 Comprehensive Safety Assessment indicated client B was able to cross the street independently. The			

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	assessment indicated "...Resident likes to elope. Also has a history of being irresponsible with fire...." The 1/31/14 assessment indicated "...Also monitor to prevent elopement and/or theft...Staff should have constant visual of individual during waking hours and 15 minute checks done during sleeping hours....." Client B's 5/1/14 revised Behavioral Support Plan (BSP) "...He often combines target behaviors, theft and elopement, and walks to nearby gas station where he 'well known and watched' (staff wording)...." Client B's 5/1/14 revised BSP indicated client B's elopement was defined as "Leaving the assigned area without (1) notifying staff or responsible person of his intention to leave supervision prior to departing and/or (2) leaving the assigned area or supervision by staff after being declined permission to leave the area by staff...." Client B's 5/1/14 BSP indicated "...If [client B's] elopement increases to more than 5 times per month, or if [client B] elopes and remains out of direct supervision from ESN (Extensive Support Needs) staff for more than one hour, the BSP procedures will be reviewed...." Client B's 12/31/13 Individual Support Plan (ISP) and/or 5/1/14 BSP indicated the facility/client's interdisciplinary team (IDT) neglected to			

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	address client B's 1/31/14 safety assessment's recommendation to have "constant visual of individual." Client B's ISP and/or BSP indicated the facility neglected to specifically indicate how client B, who had a history of eloping, was to be monitored and/or supervised to prevent the client from eloping from the group home. Interview with staff #6 on 6/24/14 at 6:09 PM indicated client B had eloped from the group home. Staff #6 stated client B eloped "every other day in the past 2 weeks. He will do whatever he can to get back there (hospital)." Staff #6 stated since client B's 6/22/14 incident, client B was "to be in line of sight except when in his room and in the bathroom." Staff #6 stated "He (client B) was incarcerated." Struck Q (QIDP) in front of police." Interview with staff #5 on 6/24/14 at 6:21 PM indicated she thought client B had pedestrian safety skills. When asked how client B was doing, staff #5 stated "Eloping a lot. Goes to [name of gas station]." Staff #5 indicated they were to keep client B in line of sight and to encourage the client to come back to the group home. Staff #5 stated "We are to encourage him to put on the orange vest for safety." Staff #5 indicated client B would often elope at night.			

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	Interview with staff #11 on 6/24/14 at 6:49 PM stated "Someone on him (client B) all the time." Staff #11 stated client B had eloped "3 times since I've been here." Staff #11 stated "He usually comes back when we redirect. This incident (6/22/14) was shocking. Not like him." Interview with staff #8 on 6/25/14 at 3:21 PM indicated client B was watching TV in the front common area when he was asked to go to his bedroom on 6/22/14. When asked what time client B came up missing, staff #8 stated "not exactly sure of time." Staff #8 indicated client B was standing in his bedroom when she went to switch from the group home phone to her cell phone when talking with the 911 dispatcher. Staff #8 indicated she thought that was around 10:35 PM. Staff #8 indicated they searched around the yard. Staff #8 stated "It was so dark. Got in car but did not find him." When asked how often client B eloped, staff #8 stated "All the time in the past 2 weeks." Interview with staff #3 on 6/25/14 at 4:20 PM indicated client B was sitting on the couch in the living room after 10 PM. Staff #3 indicated she noticed client B was missing after the paramedics left with client A to go to the hospital. Staff #3 indicated she looked in the back yard,			

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	throughout the house and went down to the gas station. Staff #3 indicated she could not locate client B. Staff #3 indicated it was dark and she could not see on the country road. Staff #3 indicated she also went down another local street to see if she could see client B. Staff #3 did not know when client B went missing from the group home. Staff #3 indicated client B was on 15 minute (routine) checks prior to the incident. Staff #3 stated "Every 15 minutes eyes on him." Staff #3 stated client B had been on "5 or 10 minute checks for a period of time for elopement." Interview with staff #4 on 6/25/14 at 4:45 PM indicated she was working the night client B eloped. Staff #4 indicated client B was sitting out in the living room area but he was asked to go to his bedroom when client A choked in the home. Staff #4 indicated there were 3 staff working at the time of the incident, but all 3 staff were involved client A. Staff #4 indicated she and another staff were doing CPR and the other staff was on the phone with the 911 dispatcher. Staff #4 indicated she did not know client B was missing until she returned from the hospital around 12:45 AM. Staff #4 indicated client B was on 15 minute checks which were routine at the time of the incident. Staff #4 stated "He is on 15			

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	minute checks. If elopes 5 minute checks." When asked how often the client eloped, staff #4 stated "As of late, quite a bit." Interview with administrative staff #1, staff #1 and the QIDP on 6/25/14 at 6:52 PM indicated client B eloped the night client A died from choking. Administrative staff #1 indicated the facility was still investigating the 6/22/14 elopement incident. The QIDP indicated 5 minute checks were not a part of client B's BSP as of 6/24/14. The QIDP indicated they suspected client B eloped from the group home by going over the back fence. The QIDP and administrative staff #1 indicated a lot of people were in the home on 6/22/14 due to the client A's choking. Staff #1 and the QIDP indicated client B could have left through the front door as the door was open due to the emergency personnel in the home. When asked if client B's IDT met after the client's elopements, the QIDP indicated the team had met but there was no documentation of the meetings. The QIDP indicated the IDT met through email and phone conference. The QIDP indicated client B was placed on 5 minute checks due to threats of suicide. Staff #1 and the QIDP indicated 15 minute checks were routine checks. The QIDP indicated client B's IDT met on 6/24/14 and put in			

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	place guidelines for monitoring client B. The facility's policy and procedure was reviewed on 6/24/14 at 2:16 PM. The facility's 2/27/14 policy and procedure entitled Policy and Procedure concerning Abuse, Neglect and Exploitation indicated "This policy establishes Dungarvin's procedures to prevent...neglect...Abuse, neglect or exploitation of the individuals' served is strictly prohibited in any Dungarvin service delivery setting...." The facility's policy and procedure indicated "...Neglect is defined as failure to provide appropriate care, supervision or training, failure to provide food and medical services as needed,...." The policy indicated "...All individuals supported by Dungarvin, are assessed at minimum annually or as often as necessary, to identify his/her susceptibility to abuse, neglect, or exploitation in the home and/or in the community to assure their safety. In addition, any potential risk is addressed during regular meetings of the individual's support team (IST) throughout the year. As services are modified, the potential risks associated with each change shall be evaluated...2. At regularly scheduled reviews and at any time the need arises, the recommendation for further assessment may be made by the IST based on the behavior and skill			

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	development of the individual....." This federal tag relates to complaint #IN00151484. 9-3-2(a)			
W000153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on interview and record review for 1 of 5 allegations of abuse and/or neglect reviewed, the facility failed to immediately report an allegation of possible neglect (choking incident) immediately to the administrator and/or to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b)(5) and to Adult Protective Services (APS) per IC 12-10-3. Findings include: The facility's staff communication book was reviewed on 6/24/14 at 7:10 PM. A 4/1/14 note indicated "[Client A] had a choking episode @ (at) the dinner table with his Veggies. Staff assisted him and he was ok, no more problems with [client	W000153	**W 153 483.420(d)(2) STAFF TREATMENT OF CLIENTS** In conjunction with the Plans of Correction for W102, W104, W122, and W149, the House Manager, QDDP, Nurse, and Behaviorist will review this Condition of Participation. Dungarvin has written policies and procedures that prohibit mistreatment, neglect, or abuse of our Individuals Served. This Policy specifically states that staff are to immediately report to the Supervisor (who will in-turn immediately report to the Administrator and DDARS/BDDS) any actual or suspected abuse, neglect, or exploitation of an Individual Served. All staff have been re-trained on Dungarvin's Abuse, Neglect, and Exploitation Policy, with an emphasis on appropriate monitoring of Individual's in an ICF-ESN setting, and per their ISP and BSP	08/06/2014

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	A], he said he know what to do (sic)." The facility's reportable incident reports and/or investigations were reviewed on 6/24/14 at 2:05 PM. The facility's reportable incident reports and/or investigations from 1/14 to the present indicated facility staff did not report the possible allegation of neglect/choking incident immediately to the administrator. Interview with administrative staff #1, staff #1 and the Qualified Intellectual Disabilities Professional (QIDP) on 6/25/14 at 6:52 PM indicated they were not aware of the 4/1/14 choking incident. Staff #1 indicated facility staff did not call her to tell her about the incident. The QIDP indicated she also was not aware of the incident. Administrative staff #1 indicated he was not made aware of the incident until he was told of the incident on 6/25/14. This federal tag relates to complaint #IN00151484. 9-3-2(a)		Protocol. For example, if two individuals are on one side of the house and another is in their bedroom on the other side, there *must* be a staff person on the side of the house where the individual is in their bedroom. All staff have been re-trained on Dungarvin's Reporting Policy, with an emphasis on reporting anything unusual, anything that may be a health/safety concern, and if one is unsure whether or not to report it, they should report it. Per Policy, once reported to the Supervisor, the Supervisor will then report to the Administrator and DDARS/BDDS. All staff have been re-trained on all Individuals' ISPs and Risk Plans. All staff have been re-trained on all Individuals' protocol in regards to periodic checks during private time, room sweeps, or any other checks according to their ISP and/or BSP. All staff have been re-trained on documentation needing to be completed according to the Individual's ISP, BSP, Risk Plans, and Dungarvin Policy. All staff have been trained on emergency protocol, with an emphasis on the plan to continue to monitor the other individuals in the event of an emergency where staff resources are concentrated on one or two of the individuals, including calling Q/House Manager for additional, immediate staff supports if necessary. QDDP interviewed staff and	

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			Individuals have been interviewed in regards to their identified needs and risks. All newly identified needs and/or risks have been presented to the IDT s and safe-guards put in their ISPs and/or Risk plans, and all staff have been trained on these revised ISPs and/or risk plans. QDDP reviewed all assessments to ensure all risks and needs identified have been addressed with the Individual's IDT and put in their ISP and/or risk plan. All staff have been trained on these revised ISPs and/or risk plans. House Manager, QDDP, and Nurse reviewed all of last 3 months of documentation, paying strict attention to trends, identified possible health/safety issues, needed risk plans, needed staff training, behavior trends, etc. All identified trends have been reviewed by AD and individual's IDT, and addressed through the Individual's ISP, BSP, and/or risk plans. All staff have been trained on these revised ISPs and/or risk plans. QDDP or House Manager have maintained daily contact/conversation with staff, including asking if there are any issues or incidents that need to be reported to the supervisor. Beginning 6/26/14 and continuing through 7/26/14, and then every week thereafter if in compliance, Q and/or House manager have been reviewing all documentation daily and all identified risks, trends, health and safety issues have been presented/ addressed promptly by the Individual's IDT, put in their ISP,	

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			BSP, and/or risk plans, and all staff have been trained on the revised plans. Any staff responsible for not following Policy/Procedure in regards to reporting significant issues have received disciplinary action. Notes of these documentation reviews have been forwarded to the Area Director. Beginning 6/26/14 and continuing through 7/26/14 then every week thereafter if in compliance, QDDP, House Manager, Nurse, and/or Behaviorist have been conducting observations to ensure staff are following the Individual's plans and following policy/procedures. **Will be completed by: 8/6/14** **Persons Responsible: Area Director, House Manager, Nurse, Behaviorist, and QDDP**	
W000227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview and record review for 1 of 2 sampled clients (A), the client's Individual Support Plan (ISP) failed to address the client's identified behavioral need. Findings include: The facility's reportable incident reports	W000227	**W 227 483.440(c)(4)** **INDIVIDUAL PROGRAM PLAN** The House Manager and QDDP will review this Condition of Participation. Dungarvin has written policies and procedures that prohibit mistreatment, neglect, or abuse of our Individuals Served. All staff have been re-trained on Dungarvin's Abuse, Neglect, and Exploitation	08/06/2014

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	and/or investigations were reviewed on 6/24/14 at 2:05 PM. The facility's 6/22/14 reportable incident report indicated "On 6/22/2014 at 10:20 PM [client A] had just finished cleaning his room and making up his bed. Staff then left to go into the office to start doing paperwork. Another staff went into his room to do a fifteen minute check on him. That staff saw [client A] lying down on his bed resting. Five minutes later [client A] came out of his bedroom running into the common area front (sic) choking. Staff immediately started doing the Heimlich maneuver but nothing came up. Another staff also did the Heimlich on [client A] but [client A] began to panic and pushed staff back to get away from staff. [Client A] walked away from staff and fell on the floor face forward. One staff immediately turned him over, checked [client A's] mouth for food and in the process [client A] bit down on staff's index finger. Staff started CPR (Cardiopulmonary Resuscitation) (sic) another called 911. Staff (staff #3 and #4) took turns administering CPR. [Client A] attempted to get up but fall (sic) back down again. Staff started CPR (staff #3 and #4 still alternating and performing CPR) again, being walked through it by 911 operator. Twenty minutes later the paramedics arrived and at first watched staff doing CPR.		Policy, with an emphasis on appropriate monitoring of Individual's in an ICF-ESN setting, and per their ISP and BSP Protocol. For example, if two individuals are on one side of the house and another is in their bedroom on the other side, there *must* be a staff person on the side of the house where the individual is in their bedroom. All staff have been re-trained on Dungarvin's Reporting Policy, with an emphasis on reporting anything unusual, anything that may be a health/safety concern, and if one is unsure whether or not to report it, they should report it. Per Policy, once reported to the Supervisor, the Supervisor will then report to the Administrator and DDARS/BDDS. All staff have been re-trained on all Individuals' ISPs and Risk Plans. All staff have been re-trained on all Individuals' protocol in regards to periodic checks during private time, room sweeps, or any other checks according to their ISP and/or BSP. All staff have been re-trained on documentation needing to be completed according to the Individual's ISP, BSP, Risk Plans, and Dungarvin Policy. All staff have been trained on emergency protocol, with an emphasis on the plan to continue to monitor the other individuals in the event of an emergency where staff resources are concentrated on one or two of the individuals, including calling Q/House Manager for additional, immediate staff supports if	

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	Another staff asked them if they were going to take over or try to help and the medic stated yes. The EMT (Emergency Medical Technician) then slowly got on the floor and started administering CPR. The fire department, police officers and more paramedics arrived. The medics asked staff if they tried to get any food out of his mouth and staff stated that yes she checked for food but that he bit down on her finger and to please check again. Medics continued CPR and finally used a Medical tool to pull clumped up taco bread out of his mouth. The paramedics then put him on oxygen and attached a machine to his chest before taking [client A] to the hospital. The QDDP (Qualified Developmental Disabilities Professional) and nurse was (sic) notified. The QDDP requested a room sweep be done to see if any food was found in his room and none was found. The nurse then met staff at the hospital to see how [client A] was doing. An hour after being there the hospital staff then came out to ask staff and the nurse what happened. After explaining everything to the hospital staff, hospital staff left but came back twenty minutes later and informed the nurse and staff that [client A] passed away...." During the 6/24/14 observation period between 4:20 PM and 7:40 PM, at the		necessary. QDDP interviewed staff and Individuals have been interviewed in regards to their identified needs and risks. All newly identified needs and/or risks have been presented to the IDT s and safe-guards put in their ISPs and/or Risk plans, and all staff have been trained on these revised ISPs and/or risk plans. QDDP reviewed all assessments to ensure all risks and needs identified have been addressed with the Individual's IDT and put in their ISP and/or risk plan. All staff have been trained on these revised ISPs and/or risk plans. House Manager, QDDP, and Nurse reviewed all of last 3 months of documentation, paying strict attention to trends, identified possible health/safety issues, needed risk plans, needed staff training, behavior trends, etc. All identified trends have been reviewed by AD and individual's IDT, and addressed through the Individual's ISP, BSP, and/or risk plans. All staff have been trained on these revised ISPs and/or risk plans. QDDP or House Manager have maintained daily contact/conversation with staff, including asking if there are any issues or incidents that need to be reported to the supervisor. Beginning 6/26/14 and continuing through 7/26/14, and then every week thereafter if in compliance, Q and/or House manager have been reviewing all documentation daily and all identified risks, trends, health	

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	group home, client A's bedroom was located in the back hallway across from the back living room area. The kitchen's entrance and pantry area were in the back hallway leading to client A's bedroom. The group home's office and main living room were located at the front of the group home with no view of the back hallway, back bathroom, 2 back bedrooms and/or pantry areas. Client A's record was reviewed on 6/25/14 at 1:51 PM. Client A's ABC Checklist (documentation of behaviors) indicated the following (not all inclusive): -2/3/14 "At approximately 1:30am [client A] came out saying he was hungry and was trying to break into other individuals (sic) rooms...." The checklist indicated client A was trying to get to another client's cup. -6/15/14 "[Client A] was in the kitchen getting a drink of water. [Client A] took anothers (sic) housemate's food and placed the plate underneath the bathroom sink...." Client A's Daily Record of Residential Habilitation Services rendered indicated the following (not all inclusive):		and safety issues have been presented/ addressed promptly by the Individual's IDT, put in their ISP, BSP, and/or risk plans, and all staff have been trained on the revised plans. Any staff responsible for not following Policy/Procedure in regards to reporting significant issues have received disciplinary action. Notes of these documentation reviews have been forwarded to the Area Director. Beginning 6/26/14 and continuing through 7/26/14 then every week thereafter if in compliance, QDDP, House Manager, Nurse, and/or Behaviorist have been conducting observations to ensure staff are following the Individual's plans and following policy/procedures. **Will be completed by: 8/6/14** **Persons Responsible: Area Director, House Manager, Nurse, Behaviorist, and QDDP**	

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	-6/8/14 Client A's note indicated client A had a toileting accident in his bed and while staff was mopping the floor, staff "...found 3 plates (empty), banana peels all under his bed and a big bottle of barbeque sauce (empty) all under his bed, and 5 cups in his room. Please staff checked (sic) on [client A] more often. No problems out of [client A] at this time." -6/15/14 "[Client A] woke up when staff arrived, took meds then a shower. He then ate breakfast with other housemates. [Client A] then hid breakfast food that was for another housemate under bathroom sink cabinet half eaten...." Client A's 5/15/14 Behavioral Support Plan (BSP) indicated client A demonstrated the target behaviors of physical aggression, verbal aggression and property destruction. Client A's record and/or 1/9/14 Individual Support Plan (ISP) and/or BSP failed to address client A's identified behavioral need in regard to taking/hiding food to prevent the client from choking. Confidential interview Z indicated client A was at risk for choking. Confidential interview Z stated client A "would take food and hide it." Confidential interview			

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	Z stated at one time, "a whole pot" was found under the bathroom sink. Confidential interview Z stated "Apparently took (pot) off stove. Found when midnight shift came on and did sweep." Confidential interview Z stated client A's mother used to keep a "chain and pad lock" on the refrigerator at her house to keep the client from getting to food. Confidential interview Z indicated client A would try to take food out of the kitchen and would hide the food in different areas of the house. Confidential interview Z indicated client A's bedroom was located at the back of the house. Confidential interview Z stated "Kitchen and pantry blind spot." Confidential interview Z indicated facility staff would not be able to see those areas if staff were on the front side of the house. Confidential interview W indicated client A choked on 6/22/14. Confidential interview W indicated client A was a choking risk and had choked in the past. Confidential interview W indicated client A would try to go into the kitchen to get food. Confidential interview W also indicated client A would hide food to consume. Confidential interview T indicated they did not know where client A got the taco bread from. When asked if client A			

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	would hide food, confidential staff T stated "Sometimes." Confidential interview T indicated facility staff were to monitor the client when eating. When asked if client A had a behavior plan for getting food and hiding it, confidential interview T stated "Yeah, I think so." Confidential interview S indicated when asked how often client A would get/sneak food, confidential interview stated "He sneaks food a lot and write (note) in ABC." Confidential interview S stated "He always tries to sneak food." When asked if client A would hide food, confidential interview S stated "Yes. He gets creative in hiding food. We had just cleaned his room out." Confidential interview V indicated she did not see the client take any food on 6/22/14. Confidential interview V stated "He has stolen food before. He will hide and we will find it. Not an everyday thing he did." Confidential interview V indicated client A may have gotten the taco bread out of the freezer. Confidential interview V indicated she had found food under his bed in the past. Interview with the Qualified Intellectual Disabilities Professional (QIDP), staff #1 and administrative staff #1 on 6/25/14 at 6:52 PM indicated client A had choked in			

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	the past (1/13/14). The QIDP and staff #1 indicated client A had past incidents of choking when he lived with his mother at home. The QIDP #1 stated she was aware of an incident where client A "hid (cooked) rice under sink in the bathroom." When asked how client A's food stealing/sneaking was being addressed, staff #1 stated "We had an inservice Thursday of last week (6/19/14)." When asked how the facility was addressing the client's food sneaking/hiding, the QIDP stated "No formal program. Came up in discussion." The QIDP and staff #1 indicated facility staff were to encourage client A to ask staff for food so the staff could assist the client in cutting the food up. The QIDP indicated client A's ISP/BSP did not address the client's identified behavioral need of sneaking/hiding food. This federal tag relates to complaint #IN00151484. 9-3-4(a)			
W000240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review and interview for 2 of 2 sampled clients (A	W000240	**W 240 483.440(c)(6)(i)** **INDIVIDUAL PROGRAM PLAN**	08/06/2014

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	and B), the clients' Individual Support Plans (ISPs) failed to include how the clients were to be monitored and/or supervised to prevent choking of client A and to prevent elopement of client B. Findings include: 1. The facility's reportable incident reports and/or investigations were reviewed on 6/24/14 at 2:05 PM. The facility's reportable incident reports and/or investigations indicated the following: -1/13/14 "On 01/13/2014 at 12:35PM [client A] sat down to eat lunch which consisted of sloppy joe on a bun and french fries. After taking just a few bites of food [client A] got up from the table and started walking to the kitchen. Staff (staff #2 and staff #3) asked [client A] are you ok, do you need help? [Client A] did not respond but staff (staff #2 and) (sic) saw that he was having a hard time breathing and still was not responding to staff. So staff (staff #2)did (sic) the Heimlich maneuver on [client A]. [Client A] had choked on a piece of bread which came up after the Heimlich was administered. [Client A] threw up twice afterwards. Staff then gave [client A] some water and called the nurse (Registered Nurse-RN #1) to inform her		The House Manager and QDDP will review this Condition of Participation. Dungarvin has written policies and procedures that prohibit mistreatment, neglect, or abuse of our Individuals Served. All staff have been re-trained on Dungarvin's Abuse, Neglect, and Exploitation Policy, with an emphasis on appropriate monitoring of Individual's in an ICF-ESN setting, and per their ISP and BSP Protocol. For example, if two individuals are on one side of the house and another is in their bedroom on the other side, there *must* be a staff person on the side of the house where the individual is in their bedroom. All staff have been re-trained on Dungarvin's Reporting Policy, with an emphasis on reporting anything unusual, anything that may be a health/safety concern, and if one is unsure whether or not to report it, they should report it. Per Policy, once reported to the Supervisor, the Supervisor will then report to the Administrator and DDARS/BDDS. All staff have been re-trained on all Individuals' ISPs and Risk Plans. All staff have been re-trained on all Individuals' protocol in regards to periodic checks during private time, room sweeps, or any other checks according to their ISP and/or BSP. All staff have been re-trained on documentation needing to be completed according to the Individual's ISP, BSP, Risk Plans, and Dungarvin Policy. All staff have been trained on emergency	

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	about what occurred...[Client A's] food will be cut up into small sections to reduce the possibility of this happening in the future." -6/22/14 "On 6/22/2014 at 10:20 PM [client A] had just finished cleaning his room and making up his bed. Staff then left to go into the office to start doing paperwork. Another staff went into his room to do a fifteen minute check on him. That staff saw [client A] lying down on his bed resting. Five minutes later [client A] came out of his bedroom running into the common area front (sic) choking. Staff immediately started doing the Heimlich maneuver but nothing came up. Another staff also did the Heimlich on [client A] but [client A] began to panic and pushed staff back to get away from staff. [Client A] walked away from staff and fell on the floor face forward. One staff immediately turned him over, checked [client A's] mouth for food and in the process [client A] bit down on staff's index finger. Staff started CPR (Cardiopulmonary Resuscitation) (sic) another called 911. Staff (staff #3 and #4) took turns administering CPR. [Client A] attempted to get up but fall (sic) back down again. Staff started CPR (staff #3 and #4 still alternating and performing CPR) again, being walked through it by 911 operator. Twenty		protocol, with an emphasis on the plan to continue to monitor the other individuals in the event of an emergency where staff resources are concentrated on one or two of the individuals, including calling Q/House Manager for additional, immediate staff supports if necessary. QDDP interviewed staff and Individuals have been interviewed in regards to their identified needs and risks. All newly identified needs and/or risks have been presented to the IDT s and safe-guards put in their ISPs and/or Risk plans, and all staff have been trained on these revised ISPs and/or risk plans. QDDP reviewed all assessments to ensure all risks and needs identified have been addressed with the Individual's IDT and put in their ISP and/or risk plan. All staff have been trained on these revised ISPs and/or risk plans. House Manager, QDDP, and Nurse reviewed all of last 3 months of documentation, paying strict attention to trends, identified possible health/safety issues, needed risk plans, needed staff training, behavior trends, etc. All identified trends have been reviewed by AD and individual's IDT, and addressed through the Individual's ISP, BSP, and/or risk plans. All staff have been trained on these revised ISPs and/or risk plans. QDDP or House Manager have maintained daily contact/conversation with staff, including asking if there are any	

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	minutes later the paramedics arrived and at first watched staff doing CPR. Another staff asked them if they were going to take over or try to help and the medic stated yes. The EMT (Emergency Medical Technician) then slowly got on the floor and started administering CPR. The fire department, police officers and more paramedics arrived. The medics asked staff if they tried to get any food out of his mouth and staff stated that yes she checked for food but that he bit down on her finger and to please check again. Medics continued CPR and finally used a Medical tool to pull clumped up taco bread out of his mouth. The paramedics then put him on oxygen and attached a machine to his chest before taking [client A] to the hospital. The QDDP (Qualified Developmental Disabilities Professional) and nurse was (sic) notified. The QDDP requested a room sweep be done to see if any food was found in his room and none was found. The nurse then met staff at the hospital to see how [client A] was doing. An hour after being there the hospital staff then came out to ask staff and the nurse what happened. After explaining everything to the hospital staff, hospital staff left but came back twenty minutes later and informed the nurse and staff that [client A] passed away...."		issues or incidents that need to be reported to the supervisor. Beginning 6/26/14 and continuing through 7/26/14, and then every week thereafter if in compliance, Q and/or House manager have been reviewing all documentation daily and all identified risks, trends, health and safety issues have been presented/ addressed promptly by the Individual's IDT, put in their ISP, BSP, and/or risk plans, and all staff have been trained on the revised plans. Any staff responsible for not following Policy/Procedure in regards to reporting significant issues have received disciplinary action. Notes of these documentation reviews have been forwarded to the Area Director. Beginning 6/26/14 and continuing through 7/26/14 then every week thereafter if in compliance, QDDP, House Manager, Nurse, and/or Behaviorist have been conducting observations to ensure staff are following the Individual's plans and following policy/procedures. **Will be completed by: 8/6/14** **Persons Responsible: Area Director, House Manager, Nurse, Behaviorist, and QDDP**	

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	During the 6/24/14 observation period between 4:20 PM and 7:40 PM, at the group home, client A's bedroom was located in the back hallway across from the back living room area. The kitchen's entrance and pantry area were in the back hallway leading to client A's bedroom. The group home's office and main living room were located at the front of the group home with no view of the back hallway, back bathroom, 2 back bedrooms and/or pantry areas. The facility's staff communication book was reviewed on 6/24/14 at 7:10 PM. A 4/1/14 note indicated "[Client A] had a choking episode @ (at) the dinner table with his Veggies. Staff assisted him and he was ok, no more problems with [client A], he said he know what to do (sic)." Client A's record was reviewed on 6/25/14 at 1:51 PM. Client A's 1/13/14 Medical Visit Summary form indicated client A went to see his doctor as he "choke on food." The form indicated client A's doctor ordered an Upper GI swallow and a chest X-ray to be done. The 1/13/14 form indicated "One-on-one monitoring for portion sizes at all meals & (and) snacks." Client A's ABC Checklist (documentation of behaviors) indicated			

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	the following (not all inclusive): -2/3/14 "At approximately 1:30am [client A] came out saying he was hungry and was trying to break into other individuals (sic) rooms...." The checklist indicated client A was trying to get to another client's cup. -6/15/14 "[Client A] was in the kitchen getting a drink of water. [Client A] took anothers (sic) housemate's food and placed the plate underneath the bathroom sink...." Client A's Daily Record of Residential Habilitation Services rendered indicated the following (not all inclusive): -6/8/14 Client A's note indicated client A had a toileting accident in his bed and while staff was mopping the floor, staff "...found 3 plates (empty), banana peels all under his bed and a big bottle of barbeque sauce (empty) all under his bed, and 5 cups in his room. Please staff checked (sic) on [client A] more often. No problems out of [client A] at this time." -6/15/14 "[Client A] woke up when staff arrived, took meds then a shower. He then ate breakfast with other housemates. [Client A] then hid breakfast food that			

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	was for another housemate under bathroom sink cabinet half eaten...." Client A's 5/15/14 Behavioral Support Plan (BSP) indicated client A demonstrated the target behaviors of physical aggression, verbal aggression and property destruction. Client A's 12/2/13 Health Risk: Choking Plan indicated client A was at risk for choking. The plan indicated "Choking related to food texture difficulties and inability to pace self while eating/drinking. Goal: To prevent choking and aspiration while eating...." The plan indicated client A was to have "Closer supervision during eating and/or taking medication...." The plan indicated client A's food was to be cut into bite size pieces. Client A's 2/11/14 Health Risk: Risk for Aspiration Pneumonia plan indicated "...Aspiration Pneumonia secondary to risk for choking...." Client A's record and/or 1/9/14 Individual Support Plan (ISP) failed to specifically indicate how facility staff were to monitor/supervise client A to prevent the client from eating food without staff's supervision. Client A's ISP and/or BSP failed to indicate how client A's room			

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	and/or other areas of the house were to be monitored to prevent client A from hiding/consuming food without staff's knowledge/supervision. Confidential interview Z indicated client A was at risk for choking. Confidential interview Z indicated facility staff monitored client A at snacks and meal times. Confidential interview Z indicated client A received a regular diet with food cut up into 1 inch pieces with the client's liquids thickened. Confidential interview Z indicated 3 staff were on duty at the time of the choking incident. Confidential interview Z stated "He choked on bread. I don't remember seeing taco bread in the refrigerator." Confidential interview Z indicated facility staff were to monitor all clients in the home every 15 minutes and document the checks. Confidential interview Z stated "15 minute checks are normal. If he (client A) goes into the kitchen, be behind him." Confidential interview Z stated client A "would take food and hide it." Confidential interview Z stated at one time, "a whole pot" was found under the bathroom sink. Confidential interview Z stated "Apparently took (pot) off stove. Found when midnight shift came on and did sweep." Confidential interview Z stated client A's mother used to keep a "chain and pad lock" on the			

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	refrigerator at her house to keep the client from getting to food. Confidential interview Z indicated client A would try to take food out of the kitchen and would hide the food in different areas of the house. Confidential interview Z indicated client A's bedroom was located at the back of the house. Confidential interview Z stated "Kitchen and pantry blind spot." Confidential interview Z indicated facility staff would not be able to see those areas if staff were on the front side of the house. Confidential interview Y indicated when asked how client A was monitored to prevent choking, confidential interview Y stated "We are always around him. Check on him every 5 to 10 minutes." Confidential interview T indicated facility staff were to monitor the client when eating. Confidential interview S stated "He always tries to sneak food." When asked if client A would hide food, confidential interview S stated "Yes. He gets creative in hiding food. We had just cleaned his room out." Confidential interview S indicated facility staff would do 15 minute checks on the client as they were to do 15 minute checks on all clients. Confidential interview S indicated client			

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	A required supervision when eating. Confidential interview V indicated when asked how client A was supervised/monitored, confidential interview V stated "Do 15 minute checks. He has to be watched when he eats food." Confidential interview V indicated client A was a choking risk. Interview with the Qualified Intellectual Disabilities Professional (QIDP), staff #1 and administrative staff #1 on 6/25/14 at 6:52 PM indicated client A had choked in the past (1/13/14). The QIDP and staff #1 indicated client A had past incidents of choking when he lived with his mother at home. Administrative staff #1 indicated the staff interviews indicated client A came out of his bedroom choking, but administrative staff #1 indicated it appears the client was in the bathroom and came out choking. Staff #1 indicated there had not been any concerns with client A getting up at night to look for food. Staff #1 and the QIDP indicated facility staff had been told to go through client A's bedroom to search for cups. The QIDP stated she had instructed staff to monitor client A's room and clean "every other day." The QIDP indicated the above mentioned information was not part of the client's ISP/BSP. The QIDP stated "I told staff to monitor and watch			

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	informally." The QIDP indicated client A's ISP/BSP did not indicate how client A was to be supervised/monitored to prevent choking incidents. 2. The facility's reportable incident reports were reviewed on 6/25/14 at 2:05 PM. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive): -2/24/14 "On 02/24/2014 at 12:15PM [client B], staff and all of his housemates were in the community on an out (sic) when they stopped at [name of large shopping center] to get some supplies for the house. [Client B] was in the van arguing and agitating the other individuals present calling them, names which included 'retarded,' 'black n.....,' and 'stupid.' Staff tried to verbally redirect him constantly but [client B] kept telling the other individuals he would 'kick their a...,' 'that he wasn't like them' and still continuously kept calling them names. Staff continued to verbally redirect [client B] while calming the other individuals down who were now agitated. [Client B] then said 'f...you man you can't stop me' and jumped out of the van and ran towards [name of large shopping center]. Staff maintained line of sight and caught up with him to try to calm him down at the electronics section			

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	of the store. In which [client B] said he's not going back to that place, he wants to go home to his family and that he wants to go to jail (sic). Staff told him that jail was not a good place for him and continued to redirect him to the van. [Client B] then said I'm not going back to the house and ran down the aisle. Staff lost sight of [client B] for 20 seconds as he turned a corner but regained sight of him immediately. Staff caught up with [client B] and continued to try to talk to him about his feelings and why he ran away from them. [Client B] then said because I need a pop. Staff then called the QMRP (QIDP) who talked to [client B] and got him to calm enough to get into the van to go back to the group home...." A 3/3/14 follow-up report indicated "... [Client B] does have a long history of elopement in the past. [Client B] will have staff member by him at all times when riding in the van and if for some reason he runs out of the van again (sic) staff will run and keep pace with him to make sure he is within line of sight at all times...Staff will continue to implement [client B's] current elopement plan and work with [client B] to express himself using appropriate verbal communication." -4/3/14 "On 4/03/2014 [client B] was in			

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	the common area waiting to get his night meds when he decided to go into his bedroom. Staff then went into the office to start preparing to pass [client B] his 11:00PM (sic) meds. Staff then walked back into his bedroom to tell him to come into the office for his meds when he realized that [client B] was no longer in his bedroom. Staff noticed [client B] walking down the street and staff followed [client B] to the gas station (about 2 miles from group home) down the street. At the gas station, staff saw [client B] walk inside of the gas station and staff promptly follows him inside. Staff then prompts [client B] to return to the home, [client B] then walks outs (sic) and says he's not going anywhere and started smoking a cigarette. Staff then tried to verbally redirect [client B] again to return to the home but [client B] smoked another cigarette and says he would walk home. Staff then followed [client B] home and when [client B] entered the home staff asked [client B] to remove any stolen items from his pockets. [Client B] became agitated with staff and started refusing verbal cues to calm down. [Client B] did reply with staff request and revealed that he had stolen two energy drinks and two sodas. Staff told him that the stolen items would need to be returned...."			

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	-5/27/14 "[Client B] eloped from the home, staff immediately left out behind him keeping line of sight he was yelling that he was going to knock that b... out referring to the female staff both staff tried to redirect [client B] back into the home he refused several times and be gain (sic) throwing rocks and hitting staff car and company van and continued to threaten staff repeating that he was going to 'knock that b... out and shoot her '911' was called and they helped [client B] come back to the home he then told police that he was suicidal and that he wanted to go to the hospital the police thought it was best and called an ambulance to transport to [name of hospital] (sic)...." -6/16/14 "...at 11:50 PM staff gave [client B] his 12 AM medication. After taking his medicine [client B] walked toward his bedroom and staff proceeded to lock up the medication. At 11:52 staff then left out of the office to check on [client B] because he was on a five minute watch to make sure he went to his room. Staff noticed the door to the backyard slightly ajar and that the door chime had been ripped off. Staff immediately searched the house and the front yard. At 11:54 PM staff immediately saw [client B] running on the side of the road and followed him in the home van. Staff kept			

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	line of sight of [client B] and continued to try to redirect [client B] to get in the van or to start walking home. [Client B] started saying that he wanted to go to jail and refused to be redirected. Staff continued to try to verbally redirect [client B] all the way to the gas station down the street. Once at the gas station [client B] began asking people for money. Staff redirected [client B] and staff asked that no one give [client B] any money. [Client B] then started saying that he wanted to go to the hospital because he 'gets all the pop's (sic) he want there.' Staff told [client B] that the hospital is only for sick people. [Client B] then started talking about going to jail again and refused to get in the van to return home. Staff called the police to ask if they could assist in taking [client B] to the home and was told they could not. Staff notified the QDDP and the QDDP talked with [client B] about why jail or to hospital was not a good idea. Staff then gave [client B] two options to either get in the van to go home or he could walk with staff home. [Client B] then chose to get in the van to go home. Once at the home (sic) [client B] gave staff the door chime he took after it was requested of him, drunk (sic) some water and went to sleep...." -"On 6/22/2014 [client B] was asked to			

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	go to his bedroom at 10:20 PM due to an issue going on with another individual so he could be safe. Staff saw him enter his room. Ten minutes later staff checked on [client B] to see if he was in his room and confirmed he was in his room. At about 10:55 PM staff went to check on [client B] and found that he was not in his room or the home. Staff then went outside and could not find him. Staff then called the QDDP and was told to have some staff continue to look for [client B] while one staff stayed at the home to call police and be with the other individuals who were sleep (sic). The police arrived at the home to get a description of what [client B] was wearing and asked about where he normally go. The police then left the home to look for [client B]. Twenty-five minutes later the police called and told staff they found him at [name of large store] and to come pick him up. Staff arrived at [name of large store] to pick [client B] up and the QDDP asked that he emptied (sic) his pockets so that we could make sure he didn't have any knives on him due to his history of stealing pocket knives from stores. [Client B] became upset and in front of three officers started punching the QDDP in the arm and shoulder despite QDDP using approved DCI (physical intervention technique) blocking techniques before being held by the police to stop. The police then			

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	informed the QDDP that [client B] was being arrested for battery. [Client B] was taken to holding and processed on 06/23/2014. [Client B] is currently in jail and we are currently trying to bail him out. The team is having an emergency meeting tomorrow about this situation. When released from jail [client B] will have one on one (1 staff to 1 client) staffing." During the 6/24/14 observation period between 4:20 PM and 7:40 PM, at the group home, client B's bedroom was located near the back door of the group home. Alarms were heard on the front and back doors of the group home when the doors were opened. The group home's back yard was surrounded with a fence which was approximately 5 feet tall. The group home was located on a country road approximately 2 miles from the main road/highway, about a mile or a little over a mile to the large shopping center where client B was found on 6/22/14 (over 3 miles in all). The country road did not have any street lights and/or side walks. Client B's record was reviewed on 6/25/14 at 3:30 PM. Client B's 1/31/14 Comprehensive Safety Assessment indicated client B was able to cross the street independently. The assessment			

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	indicated "...Resident likes to elope. Also has a history of being irresponsible with fire...." The 1/31/14 assessment indicated "...Also monitor to prevent elopement and/or theft...Staff should have constant visual of individual during waking hours and 15 minute checks done during sleeping hours....." Client B's 5/1/14 revised Behavioral Support Plan (BSP) "...He often combines target behaviors, theft and elopement, and walks to nearby gas station where he 'well known and watched' (staff wording)...." Client B's 5/1/14 revised BSP indicated client B's elopement was defined as "Leaving the assigned area without (1) notifying staff or responsible person of his intention to leave supervision prior to departing and/or (2) leaving the assigned area or supervision by staff after being declined permission to leave the area by staff...." Client B's 12/31/13 Individual Support Plan (ISP) and/or 5/1/14 BSP indicated the client's ISP/BSP failed to specifically indicate how client B, who had a history of eloping, was to be monitored and/or supervised to prevent the client from eloping from the group home. Interview with administrative staff #1, staff #1 and the QIDP on 6/25/14 at 6:52 PM indicated client B eloped the night			

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	client A died from choking. The QIDP indicated 5 minute checks were not a part of client B's BSP as of 6/24/14. The QIDP indicated client B was placed on 5 minute checks due to threats of suicide. Staff #1 and the QIDP indicated 15 minute checks were routine checks. The QIDP indicated client B's ISP did not specifically indicate how client B was to be monitored/supervised prior to 6/24/14 other than to conduct 15 minute checks. The QIDP and staff #1 indicated client B was on 15 minute checks when he eloped from the group home on 6/22/14. The QIDP indicated client B's IDT met on 6/24/14 and put in place guidelines for monitoring client B. This federal tag relates to complaint #IN00151484. 9-3-4(a)			