

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G750		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/25/2012	
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 60680 LILAC RD SOUTH BEND, IN 46614			
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W0000	<p>This visit was for an extended recertification and state licensure survey.</p> <p>This survey was conducted in conjunction with the post certification revisit of complaint #IN00105379 and complaint #IN00106355.</p> <p>Dates of Survey: May 21, 22, and 25, 2012</p> <p>Facility number: 011765 Provider number: 15G750 AIM number: 200908290</p> <p>Surveyors: Tim Shebel, Medical Surveyor III-Team Leader Dave Piotrowski, Federal Contract Surveyor</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/4/12 by Ruth Shackelford, Medical Surveyor III.</p>			W0000			

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

TITLE

(X6) DATE

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

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W0120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client.</p> <p>Based on record review and interview, the facility failed to assure services provided by the contractual workshop protected 2 of 2 sampled clients with elopement histories (clients #1 and #2) from eloping from the workshop.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 5/21/12 at 1:33 P.M.. The following elopement incidents involving client #2 were reviewed:</p> <p>1. "On 5/10/12 at approximately 10:00 am the Dungarvin office (name of facility) was contacted that [client #2], {a client from an ESN (Extra Support Needs) group home} was being sent home (from the contractual workshop) due to insubordination and behaviors. This worker (workshop staff #1) requested staff (facility staff) be sent to pick up [client #2] and take him home {per behavior plan protocol}. A cell phone message was left with the Dungarvin's Program Director regarding the above information. [Client #2's] behaviors continued to escalate and at</p>	W0120	<p><b>W120 483.410(d)(3) Services Provided with Outside Sources</b> The Program Director/QMRP for Dungarvin will meet with the Supervising Staff for Logan Center, who provides the contracted Day Program Services to all men at the ESN home. The purpose of this meeting will be to review the current Behavior Plans for the men including how to implement protective measures during episodes of elopement. The contracted Behavior Support Specialist will also complete observations at the day program and provide immediate feedback and direction to the Day Program Staff on how to implement the behavioral plan. The Program Coordinator has also met with the administrative staff at the Logan Day Program to discuss this concern. Random checks will be done by the Program Director, Lead counselor, Behaviorist, or other designee at both the home and the day program to also assure that the behavior support plan is being followed and is also being effective in preventing elopement. System wide, all Program Director/QMRP's will review this standard and assure that this concern is being addressed at all</p>	06/24/2012			

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	<p>approximately 10:30 am [client #2] eloped from the Pre-Vocational program at [name of contractual workshop.] Per behavior plan protocol, [contractual workshop] staff [contractual workshop staff] dialed 911. One staff followed [client #2] on foot while the other followed him in their vehicle. [Client #2] walked east on [street #1] and turned north on [street #2.] By this time [client #2's] Residential Program Director (program director #1) had listened to the cell phone message and had called [contractual workshop]. He was informed that [client #2] had eloped so he drove to the location where he believed [client #2] to be. There were three attempts made to encourage [client #2] to stop eloping and voluntarily go with staff in their vehicle. [Client #2] refused and continued to walk north on [street #2.] He then crossed the street ignoring traffic and all north-south {four lane} traffic slowed to a stop. The Program Director from Dungarvin had to physically move/prompt him (client #2) out of the road, and at this time [client #2] agreed to be transported home by the Program Director. [Client #2] and his Program Director returned to the parking lot of [name of contractual workshop] so that they could speak with the police and inform them [client #2] was safe. Plan to Resolve: Due to health/safety concerns, [client #2] will not be able to attend work</p>		<p>Dungarvin ICF-MR's. <b>Persons Responsible: Program Coordinator, Program Director/QMRP</b></p>				

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	<p>at [contractual workshop] until these concerns are addressed. An emergency team meeting will be held tomorrow 5/11/12."</p> <p>2. "Date of Incident: 1/31/2012, [Client #2] arrived in the am and was immediately requesting to change workgroups as his primary training supervisor was out ill. [Client #2] was told he needed to spend the day in his workgroup as no other workgroups had any work available for him. [Client #2] demanded he go into [staff #7's] group and became very agitated wringing his hands and then hitting a puzzle box. [Client #2] was told he had to stay in his workgroup. He then stated he wanted to go home so his program coordinator phoned the group home to come and pick up [client #2.] After approximately 10 minutes [client #2] then stated he did not want to go home and that he wanted to stay at [contractual workshop] and that he would be okay. His group home was called and informed that [client #2] had changed his mind and wanted to stay. The program coordinator was monitoring [client #2] when she witnessed [client #2] leaving his workgroup. She found some activities to take to [client #2] but when she presented them to [client #2] he said again he wanted to go home. The program coordinator stated he should</p>						

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	<p>return to his group and work on the activities she had for him. [Client #2] then began striking at the program coordinator slapping her on her arms. The program coordinator told [client #2] to 'stop' and [client #2] did. [Client #2] walked into the cafeteria and per the client's behavior plan the program coordinator went to phone the Dungarvin program director. It was during this time the program coordinator observed [client #2] head out to the front lobby of the building. [Client #2] was followed and when the PC (program coordinator) saw [client #2] begin to exit the building she reminded [client #2] if he left the building the police would be called. [Client #2] chose to leave the building and 911 was called. The PC kept line of sight with [client #2] and followed him out of the building, no eye contact or verbal interaction occurred per the client's behavior plan. [Client #2] stopped by a tree and did not leave the parking lot. Another [contractual workshop] staff had come to stay with [client #2] while the PC went to answer a call from Dungarvin. [Client #2] then voluntarily returned to the building, the police called and were told they did not need to come out and [client #2] remained calm and apologetic until his Dungarvin staff came to take him home. Plan to Resolve: Per team agreement and behavior plan, [client #2]</p>						

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	<p>will be given a 'wellness day' (day off) and will return to the pre-vocational program Thursday. Residential staff have been educated by the behavior specialist on the activities that [client #2] is to partake in during his day home from the pre-vocational program."</p> <p>3. "Date: 11/14/2011, [Client #2] eloped from [contractual workshop] today at about 1:20 pm. The training supervisor was following [client #2] on foot. A code (emergency situation) was called within the building and another staff then got into her vehicle to follow [client #2]. [Client #2] remained within line of site (sic) during the entire time the incident was occurring. [Client #2] ignored the staff's request to stop nor would he get into the staff's vehicle. [Client #2] was swearing and yelling and continued to keep walking. [Client #2] put himself into a very dangerous situation by running across [street #2] which is a very busy four lane street. Staff caught up with [client #2] near [street #3]. They (workshop staff) explained to [client #2] that the police would be called if he didn't come with them. He stopped, got into the vehicle and returned to (contractual workshop) with staff. [Client #2] was questioned as to why he eloped - A few explanations were given, at first [client #2] stated it was because his training</p>			

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	<p>supervisor corrected him; he also said he was bored with the work and he also stated it was because he was mad at his behaviorist because she would not let him watch the movies he liked to watch. [Client #2] then apologized to staff for worrying them and options as to what 'he could have done' instead of eloping - were reviewed with him. Before [client #2] left for the day some other unusual behavior occurred. [Client #2] was sitting in his work group - all of a sudden he stood up and threw his chair then went over to his training supervisor's desk and knocked some things off of it. [Client #2] then went to the restroom where he started to shove another client for making noise - but no client came forward and stated they were shoved. The program coordinator then sat with [client #2] until he was picked up from day program. During their time together [client #2] was stating his father was a machine and he was a machine, but his mother did not believe him. He also said the devil talks to him and that he is going to hell. [Client #2] continued to state he was bad and that he wanted to go to hell. [Client #2] stated he was afraid of his upcoming birthday because last year he smashed his cake and he was afraid he would do that again this year. The program coordinator attempted to redirect [client #2] but [client #2] stated he did not want to talk.</p>				

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	<p>His van arrived and then [client #2] apologized for his behavior before going home. Plan to Resolve: [Client #2's] QMRP (Qualified Mental Retardation Professional) and behavior specialist were notified. The behaviorist stated she would contact the PC (Program Coordinator) tomorrow to discuss the occurrence. [Contractual workshop] will work with [client #2's] team to follow the behavior plan and any advice offered by the behavior specialist. PD/QMRP (Program Director/Qualified Mental Retardation Professional) instructed that [client #2] not attend day program until (behavior) plan had been revised to ensure his health and safety during elopement. [Contractual workshop] &amp; Behavior Specialist discussed and will revise BSP (behavior support plan) to state @ day program if [client #2] leaves the grounds 911 will be called immediately for assistance."</p> <p>The facility's records were further reviewed on 5/21/12 at 2:40 P.M.. The following elopement incident involving client #1 was reviewed:</p> <p>1. "On May 9, 2012, at approximately 2:20 pm, [client #1] was in his work area when he became agitated when another peer called him a chicken. [Client #1] became verbally aggressive and began to</p>				

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	<p>threaten to do physical harm to the peer if he called him a chicken again. The peer attempted to leave the area with another staff member. [Client #1] chased after the peer and continued to yell, shaking his fist, pointing his fingers in the peer's face and verbally threatening physical harm. The training supervisor immediately intervened and separated the two individuals. [Client #1] then stormed out of the area and went to the nurse's station. I (program coordinator) went to the nurse's station and spoke with [client #1]. I continued to attempt to de-escalate [client #1]. [Client #1] did briefly calm down, but then became upset again when I told him he would have to stay home tomorrow as a result of the verbal and physical aggression as per his behavior plan. [Client #1] became upset and stormed out of the nurse's station to the cafeteria. I followed [client #1] to the cafeteria and continued to attempt to de-escalate him. [Client #1] did calm down and walked back to his assigned work group with me. I spoke to the other peer about the incident and advised him not not call anybody names. The other peer did apologize to [client #1] and [client #1] in turn apologized to the peer. At approximately 2:45 pm, I received a call from [training supervisor] informing me that [client #1] became angry again and began to pound on the table and then</p>			
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	<p>got up and walked out of the group without any provocation. [Client #1] then exited the building through the 'vanning' doors and into the parking lot. [Program coordinator] and [program assistant] followed [client #1] as he was heading for the bus stop. [Client #1] stated 'He was running away.' Staff attempted to stop [client #1] several times, but kept walking. I met up with [client #1] and the staff on the sidewalk in front of the building. [Client #1] stated that he was leaving because he was tired of people getting him suspended. [Client #1] then turned towards the street and began to leave. I instructed [program coordinator] to have the police called as per Dungarvin's protocol when one of their ESN (Extra Support Needs) residential clients attempts to elope. I continued to follow [client #1] across the parking lot and into the lawn. [Client #1] did leave [contractual workshop] property before I was able to get him to stop and talk with me. While I was talking with [client #1], his residential van arrived to pick him and his housemates up since it was the end of day program. [Client #1] saw his van and walked back with me to his van. I instructed [program coordinator] to cancel the call to the police. Plan to Resolve: [Client #1] did in fact become verbally and physically aggressive toward a peer who called him a name. [Client #1] then</p>			
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	<p>attempted to elope from the building. Staff did follow proper protocol as set by [client #1's] IDT (Inter-Disciplinary Team) and did follow [client #1's] behavior plan. [Client #1] has had an increase in his target behaviors over the past several months. [Client #1] did have medication adjustments due to result of lab work. [Client #1's] team continues to work with [client #1's] behaviorist and psychiatrist to help reduce the severity and frequency of [client #1's] target behaviors. Day program staff will continue to monitor [client #1] and intervene as necessary to keep everyone safe. [Client #1's] day program staff will continue to work closely with [client #1's] IDT team and communicate any necessary information. [Client #1's] day program staff will continue to track data and run his behavior plan on a daily basis. All IDT team members have been notified of the incident. All necessary reports have been filed."</p> <p>Client #1's record was reviewed on 5/22/12 at 9:33 A.M.. A review of a 1/27/11 comprehensive functional assessment indicated client #1 had a history of elopement. Further review indicated client #1 had limited pedestrian safety skills. Further review of client #1's record indicated the client's 9/27/11 behavior plan did not address elopement</p>			

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	<p>and had not been changed or modified to address the current status of client #1's elopement behavior.</p> <p>Client #2's record was reviewed on 5/22/12 at 9:45 A.M.. A review of a 1/27/11 comprehensive functional assessment and a 1/20/11 comprehensive safety assessment indicated client #2 had a history of elopement. Further review indicated the client had limited pedestrian safety skills.</p> <p>Program Director #1 was interviewed on 5/22/12 at 9:50 A.M.. Program Director #1 indicated the 5/9/12 incident report involving client #1 was still open. When Program Director #1 was asked if the facility investigated the incident as potential neglect since contractual workshop identified the incident as elopement and the police were called, Program Director #1 indicated he did not investigate that specific aspect of the incident as he was more focused on addressing the behavioral aspects that occurred at the onset. Program Director #1 was asked at that time to identify any additional corrective action that had been taken by Dungarvin other than what was stated in the incident report completed by the contractual workshop. Program Director #1 indicated the contractual workshop would not implement any</p>						

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	<p>hands on physical interventions and as a result should an elopement, or elopement attempt occur in the future, the contractual workshop would still be expected to contact the police (via 911) and Dungarvin staff for assistance. When Program Director #1 was asked if the inter-disciplinary team (IDT) had met since the incident of 5/9/12 to: address the incident, revise the behavior plan; anticipate and identify any potentially new precipitating factors. He indicated the team had not yet met, but Client #1 ' s behavior plan would be revised. When further interviewed, Program Director #1 stated the workshop intervention of calling 911 should client #1 and/or client #2 should elope from the workshop "was not effective."</p> <p>9-3-1(a)</p>				

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W0122	<p><b>483.420</b> <b>CLIENT PROTECTIONS</b> The facility must ensure that specific client protections requirements are met.</p> <p>Based on observation, record review, and interview, the Condition of Participation of Client Protections is not met as the facility failed to protect the rights of 4 of 4 clients living in the facility (clients #1, #2, #3, and #4.)</p> <p>Findings include:</p> <p>Please refer to W125 as the facility failed to assure due process in the use of door alarms for 4 of 4 clients living in the group home (clients #1, #2, #3, and #4.)</p> <p>Please refer to W149 as the facility failed to implement their abuse/neglect policy for 5 of 5 reviewed incidents of elopement to protect 2 of 2 sampled clients with elopement histories (clients #1 and #2) from eloping.</p> <p>Please refer to W154 as the facility failed to thoroughly investigate 1 of 1 reviewed incident of elopement as possible neglect for 1 of 2 sampled clients (client #1).</p> <p>Please refer to W156 as the facility failed to ensure the results of 1 of 1 reviewed incident investigation involving potential</p>	W0122	<p><b>W 122 483.420 CLIENT PROTECTIONS</b></p> <p>Dungarvin Policy B-2 Concerning Consumer Abuse &amp; Neglect will again be reviewed with the Program Director/QMRP of this site, as well as all Dungarvin ICF Program Director/QMRP's. This training will be done in conjunction with the concerns noted under tags W125 regarding due process, W149, W154, and W156 regarding thorough and timely investigations of injuries of unknown origin, and tag W157 regarding assuring that effective correction action is implemented regarding behavioral incidents.</p> <p>The plan of correction for this condition and all related tags is as follows: W125: All of the individuals at the ESN home will have their assessments reviewed to see if they are in need of having door alarms due to elopement behaviors. For those men who are in need of this, it will be reviewed by their parents/legal guardians and IDT's for approval, and also reviewed by Dungarvin's Human Rights Committee for approval of the use of the alarms. For those men who are not in need of this, permission to utilize these</p>	06/24/2012

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	<p>neglect related to an elopement for 1 of 2 clients in the sample (client #1) were reported to the facility administrator or designee within five working days.</p> <p>Please refer to W157 as the facility failed to implement effective corrective actions in 5 of 5 reviewed incidents of elopement to protect 2 of 2 sampled clients with elopement histories (clients #1 and #2) from eloping.</p> <p>9-3-2(a)</p>		<p>alarms despite their being no need for those people will be sought by their families/legal guardians, IDT's and the HRC.</p> <p>The Program Director/QMRP for this site will review this standard and be trained on the expectation that any means of restriction, including the use of alarms when doors and windows are opened, must have approvals from the person's guardians and the HRC.</p> <p>Quarterly, Program Director/QMRP's will conduct audits of the client files. This audit will include assuring that approvals for all restrictions are in place and reviewed at least annually. This audit will be reviewed by the Program Coordinator to assure the concerns are being addressed.</p> <p>W149: Dungarvin has a written policy and procedures in place that prohibits mistreatment, neglect or abuse of the clients (Policy B-2). The Program Director has reviewed Policy B-2, including the need to prevent individuals with histories of elopement from eloping. The Program Director and outside Behaviorist will assist the day program provider to develop and implement a plan to prevent the individuals from eloping from the day program facility.</p> <p>The Program Coordinator has also met with the administrative staff at the Logan Day Program to discuss</p>		

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			<p>this concern. Random checks will be done by the Program Director, Lead counselor, Behaviorist, or other designee at both the home and the day program to also assure that the behavior support plan is being followed and is also being effective in preventing elopement.</p> <p>W154: The Program Director/QMRPs will be retrained in the investigative procedures of any allegations or complaints of abuse, mistreatment and neglect of the clients. Documentation on proof of retraining will be available for review. The Program Coordinator will monitor and supervise the Program Director/QMRP in the investigation of any allegations of abuse, mistreatment and neglect, including elopement. All investigative reports will be submitted to BDDS as follow-up reports and copies will be maintained in the office for review.</p> <p>W156: Dungarvin has a written policy and procedures in place that prohibits mistreatment, neglect or abuse of the clients (Policy B-2). The Program Director has been retrained on Policy B-2, including the expectation that the findings of all investigations of abuse and neglect must be reported to the facility administrator within 5 business days.</p> <p>The Program Coordinator will review all incident reports and ensure that a summary of each investigation is</p>		

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			<p>submitted in a timely manner.</p> <p>W157: The Program Director/QMRP will review this standard. Going forward, all incidents of elopement will be reviewed by the Program Coordinator to ensure that aggressive corrective action is implemented immediately following each incident.</p> <p>The IDT has met for client #1 with the day program provider, and new criteria has been implemented to assure that action regarding attempts of elopement is taken. The outside Behavior Specialist has been observing at the day program several days a week to assure that the plan is being implemented correctly and that the plan is effective as written, and also to assist client #1 with understanding the plan and providing him with training in coping techniques.</p> <p>Client #2 is no longer attending the outside day program. His IDT has met to discuss alternatives for him to get his vocational needs met while also being in a safe environment. The Behavior Specialist is also meeting with him at least weekly at the home to assist him with training in coping techniques regarding elopement as well.</p> <p>System wide, all Program Director/QMRP's and Program Coordinators will review this standard and assure that this concern is being addressed at all</p>		

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			Dungarvin ICF-MR's. <b>Persons Responsible: Program Coordinator, Program Director (QMRP)</b>		

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W0125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review and interview, the facility failed to assure due process in the use of door alarms for 4 of 4 clients living in the group home (clients #1, #2, #3, and #4).</p> <p>Findings include:</p> <p>Clients #1, #2, #3, and #4 were observed at the group home during the 5/21/12 observation period from 4:35 P.M. until 7:15 P.M., and on 5/22/12 from 6:00 A.M. until 8:15 A.M.. During both observations a door alarm would sound when clients #1, #2, #3, and #4 used the doors to enter or exit the facility.</p> <p>Direct care staff #1 was interviewed on 5/22/12 at 8:17 A.M.. Direct care staff #1 stated "the door alarms sound to alert staff when clients enter or leave the group home."</p> <p>Client #1's record was reviewed on 5/22/12 at 9:33 A.M.. A review of the client's 1/20/11 Comprehensive</p>	W0125	<p><b>W 125 483.420 Protection of Client Rights</b></p> <p>All of the individuals at the ESN home will have their assessments reviewed to see if they are in need of having door alarms due to elopement behaviors. For those men who are in need of this, it will be reviewed by their parents/legal guardians and IDT's for approval, and also reviewed by Dungarvin's Human Rights Committee for approval of the use of the alarms. For those men who are not in need of this, permission to utilize these alarms despite their being no need for those people will be sought by their families/legal guardians, IDT's and the HRC.</p> <p>The Program Director/QMRP for this site will review this standard and be trained on the expectation that any means of restriction, including the use of alarms when doors and windows are opened, must have approvals from the person's guardians and the HRC.</p> <p>Quarterly, Program Director/QMRP's will conduct audits of the client files. This audit will include assuring that approvals for all restrictions are in place and reviewed at least</p>	06/24/2012			

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	<p>Functional Assessment failed to indicate the client required the use of a door alarm.</p> <p>Client #2's record was reviewed on 5/22/12 at 9:45 A.M.. A review of the client's 1/20/11 Comprehensive Functional Assessment failed to indicate the client required the use of a door alarm.</p> <p>Client #3's record was reviewed on 5/22/12 at 10:38 A.M.. A review of the client's 1/20/11 Comprehensive Functional Assessment failed to indicate the client required the use of a door alarm.</p> <p>Client #4's record was reviewed on 5/22/12 at 10:25 A.M.. A review of the client's 1/20/11 Comprehensive Functional Assessment failed to indicate the client required the use of a door alarm.</p> <p>Human Rights Committee records from 5/21/11 to 5/21/12 were reviewed on 5/22/12 at 9:33 AM. The review failed to indicate the facility's Human Rights Committee reviewed the restriction of door alarms on all exit doors of the facility which affected clients #1, #2, #3, and #4 who live at the facility.</p> <p>Program Director #1 was interviewed on 5/22/12 at 11:07 A.M.. Program Director #1 indicated current assessments were needed to determine if clients #1, #2, #3,</p>		<p>annually. This audit will be reviewed by the Program Coordinator to assure the concerns are being addressed. System wide, all Program Director/QMRP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's.</p> <p><b>Persons Responsible: Program Director/ QMRP, Program Coordinator</b></p>		

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	and #4 required the use of door alarms.  9-3-2(a)				

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview, the facility failed to implement their abuse/neglect policy for 5 of 5 reviewed incidents of elopement to protect 2 of 2 sampled clients with elopement histories (clients #1 and #2) from eloping.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 5/21/12 at 1:33 P.M.. The following elopement incidents involving client #2 were reviewed:</p> <p>1. "On 5/10/12 at approximately 10:00 am the Dungarvin office (name of facility) was contacted that [client #2], {a client from an ESN (Extra Support Needs) group home} was being sent home (from the contractual workshop) due to insubordination and behaviors. This worker (workshop staff #1) requested staff (facility staff) be sent to pick up [client #2] and take him home {per behavior plan protocol}. A cell phone message was left with the Dungarvin's Program Director regarding the above information. [Client #2's] behaviors continued to escalate and at</p>	W0149	<p><b>W 149 483.420(d)(1) STAFF TREATMENT OF CLIENTS</b> Dungarvin has a written policy and procedures in place that prohibits mistreatment, neglect or abuse of the clients (Policy B-2). The Program Director has reviewed Policy B-2, including the need to prevent individuals with histories of elopement from eloping. The Program Director and outside Behaviorist will assist the day program provider to develop and implement a plan to prevent the individuals from eloping from the day program facility. The Program Coordinator has also met with the administrative staff at the Logan Day Program to discuss this concern. Random checks will be done by the Program Director, Lead counselor, Behaviorist, or other designee at both the home and the day program to also assure that the behavior support plan is being followed and is also being effective in preventing elopement. System wide, all Program Director/QMRP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's. <b>Persons Responsible: Program Coordinator, Program</b></p>	06/24/2012			

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	<p>approximately 10:30 am [client #2] eloped from the Pre-Vocational program at [name of contractual workshop.] Per behavior plan protocol, [contractual workshop] staff [contractual workshop staff] dialed 911. One staff followed [client #2] on foot while the other followed him in their vehicle. [Client #2] walked east on [street #1] and turned north on [street #2]. By this time [client #2's] Residential Program Director (program director #1) had listened to the cell phone message and had called [contractual workshop.] He was informed that [client #2] had eloped so he drove to the location where he believed [client #2] to be. There were three attempts made to encourage [client #2] to stop eloping and voluntarily go with staff in their vehicle. [Client #2] refused and continued to walk north on [street #2]. He then crossed the street ignoring traffic and all north-south {four lane} traffic slowed to a stop. The Program Director from Dungarvin had to physically move/prompt him (client #2) out of the road, and at this time [client #2] agreed to be transported home by the Program Director. [Client #2] and his Program Director returned to the parking lot of [contractual workshop] so that they could speak with the police and inform them [client #2] was safe. Plan to Resolve: Due to health/safety concerns, [client #2] will not be able to attend work</p>		Director/QMRP				

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	<p>at [contractual workshop] until these concerns are addressed. An emergency team meeting will be held tomorrow 5/11/12."</p> <p>2. "On 3/26/12 at approximately 3:30pm, and while the transportation van was stopped at a red light, [client #2] got out and began running away from the van. Plan to Resolve: Staff put the van in park for a brief period and went after [client #2] to ensure his health and safety, as he (client #2) was not paying attention to traffic. Staff unsuccessfully prompted [client #2] to come back to the van. Staff then returned to the van. While returning, staff immediately called police to assist, per protocol, due to additional individuals on van needing supervision. Staff called PD (program director #1), per protocol, to inform. PD has clarified with all staff the procedure in which no fewer than two staff should be on the van during transportation, when there is more than one individual being transported. Responsible staff has been suspended pending investigation due to the possibility that neglect may have occurred. PD will follow-up with [client #2's] IDT (Inter-Disciplinary Team) and behaviorist in order to review his BSP (Behavior Support Plan) and determine if revisions should be made."</p>			

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	<p>3. "Date of Incident: 1/31/2012, [Client #2] arrived in the am and was immediately requesting to change workgroups as his primary training supervisor was out ill. [Client #2] was told he needed to spend the day in his workgroup as no other workgroups had any work available for him. [Client #2] demanded he go into [staff #7's] group and became very agitated wringing his hands and then hitting a puzzle box. [Client #2] was told he had to stay in his workgroup. He then stated he wanted to go home so his program coordinator phoned the group home to come and pick up [client #2.] After approximately 10 minutes [client #2] then stated he did not want to go home and that he wanted to stay at [contractual workshop] and that he would be okay. His group home was called and informed that [client #2] had changed his mind and wanted to stay. The program coordinator was monitoring [client #2] when she witnessed [client #2] leaving his workgroup. She found some activities to take to [client #2] but when she presented them to [client #2] he said again he wanted to go home. The program coordinator stated he should return to his group and work on the activities she had for him. [Client #2] then began striking at the program coordinator slapping her on her arms. The program coordinator told [client #2]</p>			

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	to 'stop' and [client #2] did. [Client #2] walked into the cafeteria and per the client's behavior plan the program coordinator went to phone the Dungarvin program director. It was during this time the program coordinator observed [client #2] head out to the front lobby of the building. [Client #2] was followed and when the PC (program coordinator) saw [client #2] begin to exit the building she reminded [client #2] if he left the building the police would be called. [Client #2] chose to leave the building and 911 was called. The PC kept line of sight with [client #2] and followed him out of the building, no eye contact or verbal interaction occurred per the client's behavior plan. [Client #2] stopped by a tree and did not leave the parking lot. Another [contractual workshop] staff had come to stay with [client #2] while the PC went to answer a call from Dungarvin. [Client #2] then voluntarily returned to the building, the police called and were told they did not need to come out and [client #2] remained calm and apologetic until his Dungarvin staff came to take him home. Plan to Resolve: Per team agreement and behavior plan, [client #2] will be given a 'wellness day' (day off) and will return to the pre-vocational program Thursday. Residential staff have been educated by the behavior specialist on the activities that [client #2] is to						

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	<p>partake in during his day home from the pre-vocational program."</p> <p>4. "Date: 11/14/2011, [Client #2] eloped from [contractual workshop] today at about 1:20 pm. The training supervisor was following [client #2] on foot. A code (emergency situation) was called within the building and another staff then got into her vehicle to follow [client #2]. [Client #2] remained within line of site (sic) during the entire time the incident was occurring. [Client #2] ignored the staff's request to stop nor would he get into the staff's vehicle. [Client #2] was swearing and yelling and continued to keep walking. [Client #2] put himself into a very dangerous situation by running across [street #2] which is a very busy four lane street. Staff caught up with [client #2] near [street #3]. They (workshop staff) explained to [client #2] that the police would be called if he didn't come with them. He stopped, got into the vehicle and returned to (contractual workshop) with staff. [Client #2] was questioned as to why he eloped - A few explanations were given, at first [client #2] stated it was because his training supervisor corrected him; he also said he was bored with the work and he also stated it was because he was mad at his behaviorist because she would not let him watch the movies he liked to watch.</p>						

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NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 60680 LILAC RD SOUTH BEND, IN 46614
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	<p>[Client #2] then apologized to staff for worrying them and options as to what 'he could have done' instead of eloping - were reviewed with him. Before [client #2] left for the day some other unusual behavior occurred. [Client #2] was sitting in his work group - all of a sudden he stood up and threw his chair then went over to his training supervisor's desk and knocked some things off of it. [Client #2] then went to the restroom where he started to shove another client for making noise - but no client came forward and stated they were shoved. The program coordinator then sat with [client #2] until he was picked up from day program. During their time together [client #2] was stating his father was a machine and he was a machine, but his mother did not believe him. He also said the devil talks to him and that he is going to hell. [Client #2] continued to state he was bad and that he wanted to go to hell. [Client#2] stated he was afraid of his upcoming birthday because last year he smashed his cake and he was afraid he would do that again this year. The program coordinator attempted to redirect [client #2] but [client #2] stated he did not want to talk. His van arrived and then [client #2] apologized for his behavior before going home. Plan to Resolve: [Client #2's] QMRP (Qualified Mental Retardation Professional) and behavior</p>			

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	<p>specialist were notified. The behaviorist stated she would contact the PC (Program Coordinator) tomorrow to discuss the occurrence. [Contractual workshop] will work with [client #2's] team to follow the behavior plan and any advice offered by the behavior specialist. PD/QMRP (Program Director/Qualified Mental Retardation Professional) instructed that [client #2] not attend day program until (behavior) plan had been revised to ensure his health and safety during elopement. [Contractual workshop] &amp; Behavior Specialist discussed and will revise BSP (behavior support plan) to state @ day program if [client #2] leaves the grounds 911 will be called immediately for assistance."</p> <p>The facility's records were further reviewed on 5/21/12 at 2:40 P.M.. The following elopement incident involving client #1 was reviewed:</p> <p>1. "On May 9, 2012, at approximately 2:20 pm, [client #1] was in his work area when he became agitated when another peer called him a chicken. [Client #1] became verbally aggressive and began to threaten to do physical harm to the peer if he called him a chicken again. The peer attempted to leave the area with another staff member. [Client #1] chased after the peer and continued to yell, shaking his</p>				

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	<p>fist, pointing his fingers in the peers face and verbally threatening physical harm. The training supervisor immediately intervened and separated the two individuals. [Client #1] then stormed out of the area and went to the nurse's station. I (program coordinator) went to the nurse's station and spoke with [client #1]. I continued to attempt to de-escalate [client #1]. [Client #1] did briefly calm down, but then became upset again when I told him he would have to stay home tomorrow as a result of the verbal and physical aggression as per his behavior plan. [Client #1] became upset and stormed out of the nurse's station to the cafeteria. I followed [client #1] to the cafeteria and continued to attempt to de-escalate him. [Client #1] did calm down and walked back to his assigned work group with me. I spoke to the other peer about the incident and advised him not not call anybody names. The other peer did apologize to [client #1] and [client #1] in turn apologized to the peer. At approximately 2:45 pm, I received a call from [training supervisor] informing me that [client #1] became angry again and began to pound on the table and then got up and walked out of the group without any provocation. [Client #1] then exited the building through the 'vanning' doors and into the parking lot. [Program coordinator] and [program assistant]</p>				

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	<p>followed [client #1] as he was heading for the bus stop. [Client #1] stated 'He was running away.' Staff attempted to stop [client #1] several times, but kept walking. I met up with [client #1] and the staff on the sidewalk in front of the building. [Client #1] stated that he was leaving because he was tired of people getting him suspended. [Client #1] then turned towards the street and began to leave. I instructed [program coordinator] to have the police called as per Dungarvin's protocol when one of their ESN (Extra Support Needs) residential clients attempts to elope. I continued to follow [client #1] across the parking lot and into the lawn. [Client #1] did leave [contractual workshop] property before I was able to get him to stop and talk with me. While I was talking with [client #1], his residential van arrived to pick him and his housemates up since it was the end of day program. [Client #1] saw his van and walked back with me to his van. I instructed [program coordinator] to cancel the call to the police. Plan to Resolve: [Client #1] did in fact become verbally and physically aggressive toward a peer who called him a name. [Client #1] then attempted to elope from the building. Staff did follow proper protocol as set by [client #1's] IDT (Inter-Disciplinary Team) and did follow [client #1's] behavior plan. [Client #1] has had an</p>						

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	<p>increase in his target behaviors over the past several months. [Client #1] did have medication adjustments due to result of lab work. [Client #1's] team continues to work with [client #1's] behaviorist and psychiatrist to help reduce the severity and frequency of [client #1's] target behaviors. Day program staff will continue to monitor [client #1] and intervene as necessary to keep everyone safe. [Client #1's] day program staff will continue to work closely with [client #1's] IDT team and communicate any necessary information. [Client #1's] day program staff will continue to track data and run his behavior plan on a daily basis. All IDT team members have been notified of the incident. All necessary reports have been filed."</p> <p>Client #1's record was reviewed on 5/22/12 at 9:33 A.M.. A review of a 1/27/11 comprehensive functional assessment indicated client #1 had a history of elopement. Further review indicated client #1 had limited pedestrian safety skills. Further review of client #1's record indicated the client's 9/27/11 behavior plan did not address elopement, had not been changed or modified to address the current status of client #1's elopement behavior.</p> <p>Client #2's record was reviewed on</p>				

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	<p>5/22/12 at 9:45 A.M.. A review of a 1/27/11 comprehensive functional assessment and a 1/20/11 comprehensive safety assessment indicated client #2 had a history of elopement. Further review indicated the client had limited pedestrian safety skills.</p> <p>Program Director #1 was interviewed on 5/22/12 at 9:50 A.M.. Program Director #1 indicated the 5/9/12 incident report involving client #1 was still open. When Program Director #1 was asked if the facility investigated the incident as potential neglect since contractual workshop identified the incident as elopement and the police were called, Program Director #1 indicated he did not investigate that specific aspect of the incident as he was more focused on addressing the behavioral aspects that occurred at the onset. Program Director #1 was asked at that time to identify any additional corrective action that had been taken by Dungarvin other than what was stated in the incident report completed by the contractual workshop. Program Director #1 indicated the contractual workshop would not implement any hands on physical interventions and as a result should an elopement, or elopement attempt occur in the future, the contractual workshop would still be expected to contact the police (via 911)</p>						

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	<p>and Dunganrvin staff for assistance. When Program Director #1 was asked if the inter-disciplinary team (IDT) had met since the incident of 5/9/12 to: address the incident, revise the behavior plan; anticipate and identify any potentially new precipitating factors. He indicated the team had not yet met, but Client #1 ' s behavior plan would be revised. When further interviewed, Program Director #1 stated the workshop intervention of calling 911 should client #1 and/or client #2 should elope from the workshop "was not effective."</p> <p>The facility's records were reviewed on 5/22/12 at 11:03 A.M.. A review of the facility's "Policy and Procedure Concerning Individual Abuse, Neglect, and Exploitation", dated 4/4/12, indicated, in part, the following: "Neglect or abuse of any consumer (client) is strictly prohibited in any Dunganrvin service delivery location..." and ".... *Neglect is defined as: Failure to provide appropriate supervision, care, or training."</p> <p>9-3-2(a)</p>				

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review the facility failed to thoroughly investigate 1 of 1 reviewed incident of elopement as possible neglect for 1 of 2 sampled clients (client #1).</p> <p>Findings include:</p> <p>During observations of Client #1 at the contractual workshop on 5/21/12 from 2:30 PM until 3:30 PM, client #1's Program Coordinator (PC) indicated an incident report had been completed on 5/9/12 wherein Client #1 was agitated, became verbally aggressive, and eloped from the facility. PC #1 indicated client #1 left the building, entered the parking lot, approached the street, and did not enter it, but technically left the contractual workshop when he stepped onto the property of an adjacent business. The PC also indicated local police were called per Dungarvin's policy as there was the possibility of an elopement. Per the PC, the call was later cancelled when Client #1's behavior de-escalated to the point</p>	W0154	<p><b>W 154 483.420(d)(3) STAFF TREATMENT OF CLIENTS</b> The Program Director/QMRPs will be retrained in the investigative procedures of any allegations or complaints of abuse, mistreatment and neglect of the clients. Documentation on proof of retraining will be available for review. The Program Coordinator will monitor and supervise the Program Director/QMRP in the investigation of any allegations of abuse, mistreatment and neglect, including elopement. All investigative reports will be submitted to BDDS as follow-up reports and copies will be maintained in the office for review. System wide, all Program Director/QMRP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's. <b>Persons Responsible: Program Coordinator, Program Director /QMRP</b></p>	06/24/2012			

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	<p>where he willingly entered the van that arrived from Client #1's residence to return him home.</p> <p>The facility's records were further reviewed on 5/21/12 at 2:40 P.M.. The following elopement incident involving client #1 was reviewed:</p> <p>"On May 9, 2012, at approximately 2:20 pm, [client #1] was in his work area when he became agitated when another peer called him a chicken. [Client #1] became verbally aggressive and began to threaten to do physical harm to the peer if he called him a chicken again. The peer attempted to leave the area with another staff member. [Client #1] chased after the peer and continued to yell, shaking his fist, pointing his fingers in the peers face and verbally threatening physical harm. The training supervisor immediately intervened and separated the two individuals. [Client #1] then stormed out of the area and went to the nurse's station. I (program coordinator) went to the nurse's station and spoke with [client #1]. I continued to attempt to de-escalate [client #1]. [Client #1] did briefly calm down, but then became upset again when I told him he would have to stay home tomorrow as a result of the verbal and physical aggression as per his behavior</p>						

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	<p>plan. [Client #1] became upset and stormed out of the nurse's station to the cafeteria. I followed [client #1] to the cafeteria and continued to attempt to de-escalate him. [Client #1] did calm down and walked back to his assigned work group with me. I spoke to the other peer about the incident and advised him not not call anybody names. The other peer did apologize to [client #1] and [client #1] in turn apologized to the peer. At approximately 2:45 pm, I received a call from [training supervisor] informing me that [client #1] became angry again and began to pound on the table and then got up and walked out of the group without any provocation. [Client #1] then exited the building through the 'vanning' doors and into the parking lot. [Program coordinator] and [program assistant] followed [client #1] as he was heading for the bus stop. [Client #1] stated 'He was running away.' Staff attempted to stop [client #1] several times, but kept walking. I met up with [client #1] and the staff on the sidewalk in front of the building. [Client #1] stated that he was leaving because he was tired of people getting him suspended. [Client #1] then turned towards the street and began to leave. I instructed [program coordinator] to have the police called as per Dungarvin's protocol when one of their ESN (Extra Support Needs) residential</p>			
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	<p>clients attempts to elope. I continued to follow [client #1] across the parking lot and into the lawn. [Client #1] did leave [contractual workshop] property before I was able to get him to stop and talk with me. While I was talking with [client #1], his residential van arrived to pick him and his housemates up since it was the end of day program. [Client #1] saw his van and walked back with me to his van. I instructed [program coordinator] to cancel the call to the police. Plan to Resolve: [Client #1] did in fact become verbally and physically aggressive toward a peer who called him a name. [Client #1] then attempted to elope from the building. Staff did follow proper protocol as set by [client #1's] IDT (Inter-Disciplinary Team) and did follow [client #1's] behavior plan. [Client #1] has had an increase in his target behaviors over the past several months. [Client #1] did have medication adjustments due to result of lab work. [Client #1's] team continues to work with [client #1's] behaviorist and psychiatrist to help reduce the severity and frequency of [client #1's] target behaviors. Day program staff will continue to monitor [client #1] and intervene as necessary to keep everyone safe. [Client #1's] day program staff will continue to work closely with [client #1's] IDT team and communicate any necessary information. [Client #1's] day program</p>			

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	<p>staff will continue to track data and run his behavior plan on a daily basis. All IDT team members have been notified of the incident. All necessary reports have been filed."</p> <p>On 5/22/12 at 9:50 AM Client #1's Program Director #1 presented a copy of the incident report previously submitted by the contractual workshop indicating the incident was still open. When Program Director #1 was asked if the facility investigated the incident as potential neglect since the contractual workshop identified the incident as elopement and the police were called, Program Director #1 indicated he did not investigate that specific aspect of the incident as he was more focused on addressing the behavioral aspects that occurred at the onset.</p> <p>9-3-2(a)</p>				

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W0156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on interview and record review, the facility failed to ensure the results of 1 of 1 reviewed incident investigation involving potential neglect related to an elopement for 1 of 2 clients in the sample (client #1) were reported to the facility administrator or designee within five working days.</p> <p>Findings include:</p> <p>During observations of Client #1 at contractual workshop on 5/21/12 from 2:30 PM until 3:30 PM, PC (Program Coordinator #1) indicated an incident report had been completed on 5/9/12 wherein Client #1 was agitated, became verbally aggressive and threatened physical harm. The PC indicated client #1 left the building, entered the parking lot, approached the street, and did not enter it, but technically left the contractual workshop when he stepped onto the property of the adjacent business. The PC</p>	W0156	<p><b>W 156 483.420(d)(4) STAFF TREATMENT OF CLIENTS</b> Dungarvin has a written policy and procedures in place that prohibits mistreatment, neglect or abuse of the clients (Policy B-2). The Program Director has been retrained on Policy B-2, including the expectation that the findings of all investigations of abuse and neglect must be reported to the facility administrator within 5 business days. The Program Coordinator will review all incident reports and ensure that a summary of each investigation is submitted in a timely manner. System wide, all Program Director/QMRP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's. <b>Completion Date: 6-24-12</b> <b>Persons Responsible: Program Coordinator, Program Director /QMRP</b></p>	06/24/2012	

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	<p>also indicated local police were called per facility policy as there was the possibility of an elopement. Per the PC, the call was later cancelled when client #1's behavior de-escalated to the point where he willingly entered the van that arrived from Client #1's residence to return him home.</p> <p>On 5/22/12 at 9:50 AM Program Director #1 presented a copy of the incident report previously submitted by the contractual workshop stating the case was still open. Review of the same " Incident Initial Report " completed by contractual workshop had the question, " Was the allegation of ANE (Abuse/Neglect/Exploitation) Substantiated/Not Substantiated. " This section was blank. There was no evidence the elopement issue had been investigated or summarized therefore there was no reproducible evidence documenting the results of the investigation had been presented to the Program Director's ' s supervisor, the Dungarvin administrator. Further review indicated there were no investigative findings which were reviewed by the facility's administrator.</p>						

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W0157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to implement effective corrective actions in 5 of 5 reviewed incidents of elopement to protect 2 of 2 sampled clients with elopement histories (clients #1 and #2) from eloping.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 5/21/12 at 1:33 P.M.. The following elopement incidents involving client #2 were reviewed:</p> <p>1. "On 5/10/12 at approximately 10:00 am the Dungarvin office (name of facility) was contacted that [client #2], {a client from an ESN (Extra Support Needs) group home} was being sent home (from the contractual workshop) due to insubordination and behaviors. This worker (workshop staff #1) requested staff (facility staff) be sent to pick up [client #2] and take him home {per behavior plan protocol}. A cell phone message was left with the Dungarvin's Program Director regarding the above information. [Client #2's] behaviors continued to escalate and at</p>	W0157	<p><b>W 157 483.420(d)(4) STAFF TREATMENT OF CLIENTS</b> The Program Director/QMRP will review this standard. Going forward, all incidents of elopement will be reviewed by the Program Coordinator to ensure that aggressive corrective action is implemented immediately following each incident. The IDT has met for client #1 with the day program provider, and new criteria has been implemented to assure that action regarding attempts of elopement is taken. The outside Behavior Specialist has been observing at the day program several days a week to assure that the plan is being implemented correctly and that the plan is effective as written, and also to assist client #1 with understanding the plan and providing him with training in coping techniques. Client #2 is no longer attending the outside day program. His IDT has met to discuss alternatives for him to get his vocational needs met while also being in a safe environment. The Behavior Specialist is also meeting with him at least weekly at the home to assist him with training in coping techniques regarding elopement as well. System wide, all Program</p>	06/24/2012			

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	<p>approximately 10:30 am [client #2] eloped from the Pre-Vocational program at [name of contractual workshop.] Per behavior plan protocol, [contractual workshop] staff [contractual workshop staff] dialed 911. One staff followed [client #2] on foot while the other followed him in their vehicle. [Client #2] walked east on [street #1] and turned north on [street #2]. By this time [client #2's] Residential Program Director (program director #1) had listened to the cell phone message and had called [contractual workshop.] He was informed that [client #2] had eloped so he drove to the location where he believed [client #2] to be. There were three attempts made to encourage [client #2] to stop eloping and voluntarily go with staff in their vehicle. [Client #2] refused and continued to walk north on [street #2]. He then crossed the street ignoring traffic and all north-south {four lane} traffic slowed to a stop. The Program Director from Dungarvin had to physically move/prompt him (client #2) out of the road, and at this time [client #2] agreed to be transported home by the Program Director. [Client #2] and his Program Director returned to the parking lot of [contractual workshop] so that they could speak with the police and inform them [client #2] was safe. Plan to Resolve: Due to health/safety concerns, [client #2] will not be able to attend work</p>		<p>Director/QMRP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's. <b>Completion Date: 6-24-12</b> <b>Persons Responsible: Program Coordinator, Program Director /QMRP</b></p>				

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	<p>at [contractual workshop] until these concerns are addressed. An emergency team meeting will be held tomorrow 5/11/12."</p> <p>2. "On 3/26/12 at approximately 3:30pm, and while the transportation van was stopped at a red light, [client #2] got out and began running away from the van. Plan to Resolve: Staff put the van in park for a brief period and went after [client #2] to ensure his health and safety, as he (client #2) was not paying attention to traffic. Staff unsuccessfully prompted [client #2] to come back to the van. Staff then returned to the van. While returning, staff immediately called police to assist, per protocol, due to additional individuals on van needing supervision. Staff called PD (program director #1), per protocol, to inform. PD has clarified with all staff the procedure in which no fewer than two staff should be on the van during transportation, when there is more than one individual being transported. Responsible staff has been suspended pending investigation due to the possibility that neglect may have occurred. PD will follow-up with [client #2's] IDT (Inter-Disciplinary Team) and behaviorist in order to review his BSP (Behavior Support Plan) and determine if revisions should be made."</p>						

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	<p>3. "Date of Incident: 1/31/2012, [Client #2] arrived in the am and was immediately requesting to change workgroups as his primary training supervisor was out ill. [Client #2] was told he needed to spend the day in his workgroup as no other workgroups had any work available for him. [Client #2] demanded he go into [staff #7's] group and became very agitated wringing his hands and then hitting a puzzle box. [Client #2] was told he had to stay in his workgroup. He then stated he wanted to go home so his program coordinator phoned the group home to come and pick up [client #2.] After approximately 10 minutes [client #2] then stated he did not want to go home and that he wanted to stay at [contractual workshop] and that he would be okay. His group home was called and informed that [client #2] had changed his mind and wanted to stay. The program coordinator was monitoring [client #2] when she witnessed [client #2] leaving his workgroup. She found some activities to take to [client #2] but when she presented them to [client #2] he said again he wanted to go home. The program coordinator stated he should return to his group and work on the activities she had for him. [Client #2] then began striking at the program coordinator slapping her on her arms.</p>			
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	<p>The program coordinator told [client #2] to 'stop' and [client #2] did. [Client #2] walked into the cafeteria and per the client's behavior plan the program coordinator went to phone the Dungarvin program director. It was during this time the program coordinator observed [client #2] head out to the front lobby of the building. [Client #2] was followed and when the PC (program coordinator) saw [client #2] begin to exit the building she reminded [client #2] if he left the building the police would be called. [Client #2] chose to leave the building and 911 was called. The PC kept line of sight with [client #2] and followed him out of the building, no eye contact or verbal interaction occurred per the client's behavior plan. [Client #2] stopped by a tree and did not leave the parking lot. Another [contractual workshop] staff had come to stay with [client #2] while the PC went to answer a call from Dungarvin. [Client #2] then voluntarily returned to the building, the police called and were told they did not need to come out and [client #2] remained calm and apologetic until his Dungarvin staff came to take him home. Plan to Resolve: Per team agreement and behavior plan, [client #2] will be given a 'wellness day' (day off) and will return to the pre-vocational program Thursday. Residential staff have been educated by the behavior specialist</p>						

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	<p>on the activities that [client #2] is to partake in during his day home from the pre-vocational program."</p> <p>4. "Date: 11/14/2011, [Client #2] eloped from [contractual workshop] today at about 1:20 pm. The training supervisor was following [client #2] on foot. A code (emergency situation) was called within the building and another staff then got into her vehicle to follow [client #2]. [Client #2] remained within line of site (sic) during the entire time the incident was occurring. [Client #2] ignored the staff's request to stop nor would he get into the staff's vehicle. [Client #2] was swearing and yelling and continued to keep walking. [Client #2] put himself into a very dangerous situation by running across [street #2] which is a very busy four lane street. Staff caught up with [client #2] near [street #3]. They (workshop staff) explained to [client #2] that the police would be called if he didn't come with them. He stopped, got into the vehicle and returned to (contractual workshop) with staff. [Client #2] was questioned as to why he eloped - A few explanations were given, at first [client #2] stated it was because his training supervisor corrected him; he also said he was bored with the work and he also stated it was because he was mad at his behaviorist because she would not let him</p>						

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	<p>watch the movies he liked to watch. [Client #2] then apologized to staff for worrying them and options as to what 'he could have done' instead of eloping - were reviewed with him. Before [client #2] left for the day some other unusual behavior occurred. [Client #2] was sitting in his work group - all of a sudden he stood up and threw his chair then went over to his training supervisor's desk and knocked some things off of it. [Client #2] then went to the restroom where he started to shove another client for making noise - but no client came forward and stated they were shoved. The program coordinator then sat with [client #2] until he was picked up from day program. During their time together [client #2] was stating his father was a machine and he was a machine, but his mother did not believe him. He also said the devil talks to him and that he is going to hell. [Client #2] continued to state he was bad and that he wanted to go to hell. [Client #2] stated he was afraid of his upcoming birthday because last year he smashed his cake and he was afraid he would do that again this year. The program coordinator attempted to redirect [client #2] but [client #2] stated he did not want to talk. His van arrived and then [client #2] apologized for his behavior before going home. Plan to Resolve: [Client #2's] QMRP (Qualified Mental Retardation</p>						

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	<p>Professional) and behavior specialist were notified. The behaviorist stated she would contact the PC (Program Coordinator) tomorrow to discuss the occurrence. [Contractual workshop] will work with [client #2's] team to follow the behavior plan and any advice offered by the behavior specialist. PD/QMRP (Program Director/Qualified Mental Retardation Professional) instructed that [client #2] not attend day program until (behavior) plan had been revised to ensure his health and safety during elopement. [Contractual workshop] &amp; Behavior Specialist discussed and will revise BSP (behavior support plan) to state @ day program if [client #2] leaves the grounds 911 will be called immediately for assistance."</p> <p>The facility's records were further reviewed on 5/21/12 at 2:40 P.M.. The following elopement incident involving client #1 was reviewed:</p> <p>1. "On May 9, 2012, at approximately 2:20 pm, [client #1] was in his work area when he became agitated when another peer called him a chicken. [Client #1] became verbally aggressive and began to threaten to do physical harm to the peer if he called him a chicken again. The peer attempted to leave the area with another staff member. [Client #1] chased after the</p>				

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	<p>peer and continued to yell, shaking his fist, pointing his fingers in the peers face and verbally threatening physical harm. The training supervisor immediately intervened and separated the two individuals. [Client #1] then stormed out of the area and went to the nurse's station. I (program coordinator) went to the nurse's station and spoke with [client #1]. I continued to attempt to de-escalate [client #1]. [Client #1] did briefly calm down, but then became upset again when I told him he would have to stay home tomorrow as a result of the verbal and physical aggression as per his behavior plan. [Client #1] became upset and stormed out of the nurse's station to the cafeteria. I followed [client #1] to the cafeteria and continued to attempt to de-escalate him. [Client #1] did calm down and walked back to his assigned work group with me. I spoke to the other peer about the incident and advised him not not call anybody names. The other peer did apologize to [client #1] and [client #1] in turn apologized to the peer. At approximately 2:45 pm, I received a call from [training supervisor] informing me that [client #1] became angry again and began to pound on the table and then got up and walked out of the group without any provocation. [Client #1] then exited the building through the 'vanning' doors and into the parking lot. [Program</p>			

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	<p>coordinator] and [program assistant] followed [client #1] as he was heading for the bus stop. [Client #1] stated "He was running away." Staff attempted to stop [client #1] several times, but kept walking. I met up with [client #1] and the staff on the sidewalk in front of the building. [Client #1] stated that he was leaving because he was tired of people getting him suspended. [Client #1] then turned towards the street and began to leave. I instructed [program coordinator] to have the police called as per Dungarvin's protocol when one of their ESN (Extra Support Needs) residential clients attempts to elope. I continued to follow [client #1] across the parking lot and into the lawn. [Client #1] did leave [contractual workshop] property before I was able to get him to stop and talk with me. While I was talking with [client #1], his residential van arrived to pick him and his housemates up since it was the end of day program. [Client #1] saw his van and walked back with me to his van. I instructed [program coordinator] to cancel the call to the police. Plan to Resolve: [Client #1] is a 37 year old male with the following diagnosis (sic): [Client #1] did in fact become verbally and physically aggressive toward a peer who called him a name. [Client #1] then attempted to elope from the building. Staff did follow proper protocol as set by [client #1's] IDT</p>			

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	<p>(Inter-Disciplinary Team) and did follow [client #1's] behavior plan. [Client #1] has had an increase in his target behaviors over the past several months. [Client #1] did have medication adjustments due to result of lab work. [Client #1's] team continues to work with [client #1's] behaviorist and psychiatrist to help reduce the severity and frequency of [client #1's] target behaviors. Day program staff will continue to monitor [client #1] and intervene as necessary to keep everyone safe. [Client #1's] day program staff will continue to work closely with [client #1's] IDT team and communicate any necessary information. [Client #1's] day program staff will continue to track data and run his behavior plan on a daily basis. All IDT team members have been notified of the incident. All necessary reports have been filed."</p> <p>Client #1's record was reviewed on 5/22/12 at 9:33 A.M.. A review of a 1/27/11 comprehensive functional assessment indicated client #1 had a history of elopement. Further review indicated client #1 had limited pedestrian safety skills. Further review of client #1's record indicated the client's 9/27/11 behavior plan did not address elopement and had not been changed or modified to address the current status of client #1's elopement behavior.</p>						

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	<p>Client #2's record was reviewed on 5/22/12 at 9:45 A.M.. A review of a 1/27/11 comprehensive functional assessment and a 1/20/11 comprehensive safety assessment indicated client #2 had a history of elopement. Further review indicated the client had limited pedestrian safety skills.</p> <p>Program Director #1 was interviewed on 5/22/12 at 9:50 A.M.. Program Director #1 indicated the 5/9/12 incident report involving client#1 was still open. When Program Director #1 was asked if the facility investigated the incident as potential neglect since contractual workshop identified the incident as elopement and the police were called, Program Director #1 indicated he did not investigate that specific aspect of the incident as he was more focused on addressing the behavioral aspects that occurred at the onset. Program Director #1 was asked at that time to identify any additional corrective action that had been taken by Dungarvin other than what was stated in the incident report completed by the contractual workshop. Program Director #1 indicated the contractual workshop would not implement any hands on physical interventions and as a result should an elopement, or elopement attempt occur in the future, the</p>			

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	<p>contractual workshop would still be expected to contact the police (via 911) and Dungarvin staff for assistance. When Program Director #1 was asked if the inter-disciplinary team (IDT) had met since the incident of 5/9/12 to: address the incident, revise the behavior plan; anticipate and identify any potentially new precipitating factors, etc. he indicated the team had not yet met, but Client #1 's behavior plan would be revised. When further interviewed, Program Director #1 stated the workshop intervention of calling 911 should client #1 and/or client #2 should elope from the workshop "was not effective."</p> <p>9-3-2(a)</p>				

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W0159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based on observation, interview and record review, the facility's Program Director/QMRP (Qualified Mental Retardation Professional) failed: A. To assure effective corrective actions were implemented for 5 of 5 reviewed incidents of elopement to protect 2 of 2 sampled clients with elopement histories (clients #1 and #2) from eloping; B. To ensure three training objectives were revised when successful criterion had been met for 1 of 2 clients in the sample (client #1); and, C. To assure Comprehensive Functional Assessments were reviewed at least annually for 4 of 4 clients living in the group home (clients #1, #2, #3, and #4.)</p> <p>Findings include:</p> <p>A. The facility's records were reviewed on 5/21/12 at 1:33 P.M.. The following elopement incidents involving client #2 were reviewed:</p> <p>1. "On 5/10/12 at approximately 10:00 am the Dungarvin office (name of facility) was contacted that [client #2], {a</p>	W0159	<p><b>W159 QUALIFIED MENTAL RETARDATION PROFESSIONAL</b> The Program Director/QMRP at the ESN1 home will be retrained by the Program Coordinator on assuring that effective corrective action is being implemented for incidents of elopement. Training will also include the need to revise objectives when successful criterion is met, and assuring that the Comprehensive Functional Assessment are reviewed annually for all individuals at the home. System wide, all ICF-MR Program Director/QMRP's will review this standard and ensure that this is not a concern at any Dungarvin ICF-MR. <b>Completion Date: 6-24-12</b> <b>Persons Responsible: Program Director/QMRP, Area Director</b></p>	06/24/2012	

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	<p>client from an ESN (Extra Support Needs) group home} was being sent home (from the contractual workshop) due to insubordination and behaviors. This worker (workshop staff #1) requested staff (facility staff) be sent to pick up [client #2] and take him home {per behavior plan protocol}. A cell phone message was left with the Dungarvin's Program Director regarding the above information. [Client #2's] behaviors continued to escalate and at approximately 10:30 am [client #2] eloped from the Pre-Vocational program at [name of contractual workshop.] Per behavior plan protocol, [contractual workshop] staff [contractual workshop staff] dialed 911. One staff followed [client #2] on foot while the other followed him in their vehicle. [Client #2] walked east on [street #1]and turned north on [street #2]. By this time [client #2's] Residential Program Director (program director #1) had listened to the cell phone message and had called [contractual workshop.] He was informed that [client #2] had eloped so he drove to the location where he believed [client #2] to be. There were three attempts made to encourage [client #2] to stop eloping and voluntarily go with staff in their vehicle. [Client #2] refused and continued to walk north on [street #2]. He then crossed the street ignoring traffic and all north-south {four</p>						

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	<p>lane} traffic slowed to a stop. The Program Director from Dungarvin had to physically move/prompt him (client #2) out of the road, and at this time [client #2] agreed to be transported home by the Program Director. [Client #2] and his Program Director returned to the parking lot of [contractual workshop] so that they could speak with the police and inform them [client #2] was safe. Plan to Resolve: Due to health/safety concerns, [client #2] will not be able to attend work at [contractual workshop] until these concerns are addressed. An emergency team meeting will be held tomorrow 5/11/12."</p> <p>2. "On 3/26/12 at approximately 3:30pm, and while the transportation van was stopped at a red light, [client #2] got out and began running away from the van. Plan to Resolve: Staff put the van in park for a brief period and went after [client #2] to ensure his health and safety, as he (client #2) was not paying attention to traffic. Staff unsuccessfully prompted [client #2] to come back to the van. Staff then returned to the van. While returning, staff immediately called police to assist, per protocol, due to additional individuals on van needing supervision. Staff called PD (program director #1), per protocol, to inform. PD has clarified with all staff the</p>			

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	<p>procedure in which no fewer than two staff should be on the van during transportation, when there is more than one individual being transported. Responsible staff has been suspended pending investigation due to the possibility that neglect may have occurred. PD will follow-up with [client #2's] IDT (Inter-Disciplinary Team) and behaviorist in order to review his BSP (Behavior Support Plan) and determine if revisions should be made."</p> <p>3. "Date of Incident: 1/31/2012, [Client #2] arrived in the am and was immediately requesting to change workgroups as his primary training supervisor was out ill. [Client #2] was told he needed to spend the day in his workgroup as no other workgroups had any work available for him. [Client #2] demanded he go into [staff #7's] group and became very agitated wringing his hands and then hitting a puzzle box. [Client #2] was told he had to stay in his workgroup. He then stated he wanted to go home so his program coordinator phoned the group home to come and pick up [client #2.] After approximately 10 minutes [client #2] then stated he did not want to go home and that he wanted to stay at [contractual workshop] and that he would be okay. His group home was called and informed that [client #2] had</p>			

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	<p>changed his mind and wanted to stay. The program coordinator was monitoring [client #2] when she witnessed [client #2] leaving his workgroup. She found some activities to take to [client #2] but when she presented them to [client #2] he said again he wanted to go home. The program coordinator stated he should return to his group and work on the activities she had for him. [Client #2] then began striking at the program coordinator slapping her on her arms. The program coordinator told [client #2] to 'stop' and [client #2] did. [Client #2] walked into the cafeteria and per the client's behavior plan the program coordinator went to phone the Dungarvin program director. It was during this time the program coordinator observed [client #2] head out to the front lobby of the building. [Client #2] was followed and when the PC (program coordinator) saw [client #2] begin to exit the building she reminded [client #2] if he left the building the police would be called. [Client #2] chose to leave the building and 911 was called. The PC kept line of sight with [client #2] and followed him out of the building, no eye contact or verbal interaction occurred per the client's behavior plan. [Client #2] stopped by a tree and did not leave the parking lot. Another [contractual workshop] staff had come to stay with [client #2] while the PC</p>						

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	<p>went to answer a call from Dungarvin. [Client #2] then voluntarily returned to the building, the police called and were told they did not need to come out and [client #2] remained calm and apologetic until his Dungarvin staff came to take him home. Plan to Resolve: Per team agreement and behavior plan, [client #2] will be given a 'wellness day' (day off) and will return to the pre-vocational program Thursday. Residential staff have been educated by the behavior specialist on the activities that [client #2] is to partake in during his day home from the pre-vocational program."</p> <p>4. "Date: 11/14/2011, [Client #2] eloped from [contractual workshop] today at about 1:20 pm. The training supervisor was following [client #2] on foot. A code (emergency situation) was called within the building and another staff then got into her vehicle to follow [client #2]. [Client #2] remained within line of site (sic) during the entire time the incident was occurring. [Client #2] ignored the staff's request to stop nor would he get into the staff's vehicle. [Client #2] was swearing and yelling and continued to keep walking. [Client #2] put himself into a very dangerous situation by running across [street #2] which is a very busy four lane street. Staff caught up with [client #2] near [street #3]. They</p>				

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	<p>(workshop staff) explained to [client #2] that the police would be called if he didn't come with them. He stopped, got into the vehicle and returned to (contractual workshop) with staff. [Client #2] was questioned as to why he eloped - A few explanations were given, at first [client #2] stated it was because his training supervisor corrected him; he also said he was bored with the work and he also stated it was because he was mad at his behaviorist because she would not let him watch the movies he liked to watch. [Client #2] then apologized to staff for worrying them and options as to what 'he could have done' instead of eloping - were reviewed with him. Before [client #2] left for the day some other unusual behavior occurred. [Client #2] was sitting in his work group - all of a sudden he stood up and threw his chair then went over to his training supervisor's desk and knocked some things off of it. [Client #2] then went to the restroom where he started to shove another client for making noise - but no client came forward and stated they were shoved. The program coordinator then sat with [client #2] until he was picked up from day program. During their time together [client #2] was stating his father was a machine and he was a machine, but his mother did not believe him. He also said the devil talks to him and that he is going to hell.</p>			

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	<p>[Client #2] continued to state he was bad and that he wanted to go to hell. [Client #2] stated he was afraid of his upcoming birthday because last year he smashed his cake and he was afraid he would do that again this year. The program coordinator attempted to redirect [client #2] but [client #2] stated he did not want to talk. His van arrived and then [client #2] apologized for his behavior before going home. Plan to Resolve: [Client #2's] QMRP (Qualified Mental Retardation Professional) and behavior specialist were notified. The behaviorist stated she would contact the PC (Program Coordinator) tomorrow to discuss the occurrence. [Contractual workshop] will work with [client #2's] team to follow the behavior plan and any advice offered by the behavior specialist. PD/QMRP (Program Director/Qualified Mental Retardation Professional) instructed that [client #2] not attend day program until (behavior) plan had been revised to ensure his health and safety during elopement. [Contractual workshop] &amp; Behavior Specialist discussed and will revise BSP (behavior support plan) to state @ day program if [client #2] leaves the grounds 911 will be called immediately for assistance."</p> <p>The facility's records were further reviewed on 5/21/12 at 2:40 P.M.. The</p>						

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	<p>following elopement incident involving client #1 was reviewed:</p> <p>1. "On May 9, 2012, at approximately 2:20 pm, [client #1] was in his work area when he became agitated when another peer called him a chicken. [Client #1] became verbally aggressive and began to threaten to do physical harm to the peer if he called him a chicken again. The peer attempted to leave the area with another staff member. [Client #1] chased after the peer and continued to yell, shaking his fist, pointing his fingers in the peers face and verbally threatening physical harm. The training supervisor immediately intervened and separated the two individuals. [Client #1] then stormed out of the area and went to the nurse's station. I (program coordinator) went to the nurse's station and spoke with [client #1]. I continued to attempt to de-escalate [client #1]. [Client #1] did briefly calm down, but then became upset again when I told him he would have to stay home tomorrow as a result of the verbal and physical aggression as per his behavior plan. [Client #1] became upset and stormed out of the nurse's station to the cafeteria. I followed [client #1] to the cafeteria and continued to attempt to de-escalate him. [Client #1] did calm down and walked back to his assigned work group with me. I spoke to the other</p>			
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	peer about the incident and advised him not not call anybody names. The other peer did apologize to [client #1] and [client #1] in turn apologized to the peer. At approximately 2:45 pm, I received a call from [training supervisor] informing me that [client #1] became angry again and began to pound on the table and then got up and walked out of the group without any provocation. [Client #1] then exited the building through the 'vanning' doors and into the parking lot. [Program coordinator] and [program assistant] followed [client #1] as he was heading for the bus stop. [Client #1] stated 'He was running away.' Staff attempted to stop [client #1] several times, but kept walking. I met up with [client #1] and the staff on the sidewalk in front of the building. [Client #1] stated that he was leaving because he was tired of people getting him suspended. [Client #1] then turned towards the street and began to leave. I instructed [program coordinator] to have the police called as per Dungarvin's protocol when one of their ESN (Extra Support Needs) residential clients attempts to elope. I continued to follow [client #1] across the parking lot and into the lawn. [Client #1] did leave [contractual workshop] property before I was able to get him to stop and talk with me. While I was talking with [client #1], his residential van arrived to pick him and			

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	<p>his housemates up since it was the end of day program. [Client #1] saw his van and walked back with me to his van. I instructed [program coordinator] to cancel the call to the police. Plan to Resolve: [Client #1] is a 37 year old male with the following diagnosis (sic): [Client #1] did in fact become verbally and physically aggressive toward a peer who called him a name. [Client #1] then attempted to elope from the building. Staff did follow proper protocol as set by [client #1's] IDT (Inter-Disciplinary Team) and did follow [client #1's] behavior plan. [Client #1] has had an increase in his target behaviors over the past several months. [Client #1] did have medication adjustments due to result of lab work. [Client #1's] team continues to work with [client #1's] behaviorist and psychiatrist to help reduce the severity and frequency of [client #1's] target behaviors. Day program staff will continue to monitor [client #1] and intervene as necessary to keep everyone safe. [Client #1's] day program staff will continue to work closely with [client #1's] IDT team and communicate any necessary information. [Client #1's] day program staff will continue to track data and run his behavior plan on a daily basis. All IDT team members have been notified of the incident. All necessary reports have been filed."</p>			

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	<p>Client #1's record was reviewed on 5/22/12 at 9:33 A.M.. A review of a 1/27/11 comprehensive functional assessment indicated client #1 had a history of elopement. Further review indicated client #1 had limited pedestrian safety skills. Further review of client #1's record indicated the client's 9/27/11 behavior plan did not address elopement and had not been changed or modified to address the current status of client #1's elopement behavior.</p> <p>Client #2's record was reviewed on 5/22/12 at 9:45 A.M.. A review of a 1/27/11 comprehensive functional assessment and a 1/20/11 comprehensive safety assessment indicated client #2 had a history of elopement. Further review indicated the client had limited pedestrian safety skills.</p> <p>Program Director #1 was interviewed on 5/22/12 at 9:50 A.M.. Program Director #1 indicated the 5/9/12 incident report involving client#1 was still open. When Program Director #1 was asked if the facility investigated the incident as potential neglect since contractual workshop identified the incident as elopement and the police were called, Program Director #1 indicated he did not investigate that specific aspect of the incident as he was more focused on</p>						

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	<p>addressing the behavioral aspects that occurred at the onset. Program Director #1 was asked at that time to identify any additional corrective action that had been taken by Dungarvin other than what was stated in the incident report completed by the contractual workshop. Program Director #1 indicated the contractual workshop would not implement any hands on physical interventions and as a result should an elopement, or elopement attempt occur in the future, the contractual workshop would still be expected to contact the police (via 911) and Dungarvin staff for assistance. When Program Director #1 was asked if the inter-disciplinary team (IDT) had met since the incident of 5/9/12 to: address the incident, revise the behavior plan; anticipate and identify any potentially new precipitating factors, etc. he indicated the team had not yet met, but Client #1's behavior plan would be revised. When further interviewed, Program Director #1 stated the workshop intervention of calling 911 should client #1 and/or client #2 should elope from the workshop "was not effective."</p> <p>B. On 5/21/12 at 5:00 PM, Client #1 was prompted by a direct support staff (DSS) to wash his hands prior to taking his medication. Client #1 went to a bathroom</p>						

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	<p>and independently washed his hands.</p> <p>Review of Client #1's record on 5/22/12 at 9:30 AM indicated an Individual Program Plan dated 2/10/11 was in the record. Program Director #1 was asked if a more current plan was completed. Program Director #1 retrieved and presented an Individual Support Plan (ISP) dated 2/10/12 for review.</p> <p>A training objective had been established at the 2/10/12 ISP for Client #1 to learn how to wash his hands. The baseline data was reported as being at 100% and for the review period 2/22/12 to 5/21/12, Client #1's progress had been assessed as 100% for the quarter.</p> <p>On 5/22/12 at 7:00 AM, Client #1 was observed at breakfast. He independently poured cereal into a bowl. Subsequent record review for Client #1 indicated a training objective had been established for Client #1 to prepare his own breakfast. Baseline data was recorded at 100% and for the same review period 2/22/12 - 5/21/12 Client #1 had achieved a 100% success rate in this training objective.</p>						

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	<p>In an interview with Client #1 on 5/21/12 at 3:30 PM, Client #1 indicated he goes into the community to purchase things he wants and needs. Further review indicated Client #1 had a training objective to teach him to create a shopping list of two desired items and their costs. Baseline data was recorded at 100% and for the same review period 2/22/12 - 5/21/12 Client #1 had also achieved a 100% success rate in this training objective.</p> <p>Program Director #1 was interviewed on 5/22/12 at 10:55 AM. Program Director #1 was asked if Client #1 had successfully met the criterion in the handwashing, breakfast-making and shopping training objectives. Program Director #1 indicated Client #1 had met those objectives, but no revision had been made to the plan.</p> <p>C. Client #1's record was reviewed on 5/22/12 at 9:33 A.M.. The review indicated the client's most current Comprehensive Functional Assessment was dated 1/20/11.</p> <p>Client #2's record was reviewed on</p>			
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	<p>5/22/12 at 9:45 A.M.. The review indicated the client's most current Comprehensive Functional Assessment was dated 1/20/11.</p> <p>Client #3's record was reviewed on 5/22/12 at 10:38 A.M.. The review indicated the client's most current Comprehensive Functional Assessment was dated 1/20/11.</p> <p>Client #4's record was reviewed on 5/22/12 at 10:25 A.M.. The review indicated the client's most current Comprehensive Functional Assessment was dated 1/20/11.</p> <p>Program Director #1 was interviewed on 5/22/12 at 11:07 A.M.. Program Director #1 indicated the most current Comprehensive Functional Assessments for clients #1, #2, #3, and #4 were reviewed on 1/20/11.</p> <p>9-3-3(a)</p>				

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W0255	<p>483.440(f)(1)(i) <b>PROGRAM MONITORING &amp; CHANGE</b> The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan.</p> <p>Based on observation, interview and record review, the facility failed to ensure three training objectives were revised when successful criterion had been met for 1 of 2 clients in the sample (client #1).</p> <p>Findings include:</p> <p>On 5/21/12 at 5:00 PM, Client #1 was prompted by a direct support staff (DSS) to wash his hands prior to taking his medication. Client #1 went to a bathroom and independently washed his hands.</p> <p>Review of Client #1's record on 5/22/12 at 9:30 AM indicated an Individual Program Plan dated 2/10/11 was in the record. Program Director #1 was asked if a more current plan was completed. Program Director #1 retrieved and presented an Individual Support Plan (ISP) dated 2/10/12 for review.</p>	W0255	<p><b>W255 Program Monitoring and Change</b> The Program Director/QMRP at the ESN1 home will be retrained by the Program Coordinator on the need to revise objectives when successful criterion is met as identified in the Individual Program Plan. An audit of the client files for all men at the ESN1 home will be completed and any objectives that are in need of revision will be identified and corrected at that time. System wide, all ICF-MR Program Director/QMRP's will review this standard and ensure that this is not a concern at any Dungarvin ICF-MR. <b>Completion Date: 6-24-12</b> <b>Persons Responsible: Program Director/ QMRP, Area Director</b></p>	06/24/2012	

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	<p>A training objective had been established at the 2/10/12 ISP for Client #1 to learn how to wash his hands. The baseline data was reported as being at 100% and for the review period 2/22/12 to 5/21/12, Client #1's progress had been assessed as 100% for the quarter.</p> <p>On 5/22/12 at 7:00 AM, Client #1 was observed at breakfast. He independently poured cereal into a bowl. Subsequent record review for Client #1 indicated a training objective had been established for Client #1 to prepare his own breakfast. Baseline data was recorded at 100% and for the same review period 2/22/12 - 5/21/12 Client #1 had achieved a 100% success rate in this training objective.</p> <p>In an interview with Client #1 on 5/21/12 at 3:30 PM, Client #1 indicated he goes into the community to purchase things he wants and needs. Further review indicated Client #1 had a training objective to teach him to create a shopping list of two desired items and their costs. Baseline data was recorded at 100% and for the same review period</p>						

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	<p>2/22/12 - 5/21/12 Client #1 had also achieved a 100% success rate in this training objective.</p> <p>Program Director #1 was interviewed on 5/22/12 at 10:55 AM. Program Director #1 was asked if Client #1 had successfully met the criterion in the handwashing, breakfast-making and shopping training objectives. Program Director #1 indicated Client #1 had met those objectives, but no revision had been made to the plan.</p> <p>9-3-4(a)</p>			

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W0259	<p>483.440(f)(2) PROGRAM MONITORING &amp; CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.</p> <p>Based on record review and interview, the facility failed to ensure Comprehensive Functional Assessments were reviewed at least annually for 4 of 4 clients living in the group home (clients #1, #2, #3, and #4).</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 5/22/12 at 9:33 A.M.. The review indicated the client's most current Comprehensive Functional Assessment was dated 1/20/11.</p> <p>Client #2's record was reviewed on 5/22/12 at 9:45 A.M.. The review indicated the client's most current Comprehensive Functional Assessment was dated 1/20/11.</p> <p>Client #3's record was reviewed on 5/22/12 at 10:38 A.M.. The review indicated the client's most current Comprehensive Functional Assessment was dated 1/20/11.</p> <p>Client #4's record was reviewed on</p>	W0259	<p><b>W259 Program Monitoring and Change</b> The Program Director/QMRP at the ESN1 home will be retrained by the Program Coordinator on the need to assure that the Comprehensive Functional Assessment is reviewed annually by each individual's IDT and updated if necessary. An audit of the client files for all men at the ESN1 home will be completed and any assessments that are in need of revision will be identified and corrected at that time. System wide, all ICF-MR Program Director/QMRP's will review this standard and ensure that this is not a concern at any Dungarvin ICF-MR. <b>Completion Date: 6-24-12</b> <b>Persons Responsible: Program Director/ QMRP, Area Director</b></p>	06/24/2012	

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	<p>5/22/12 at 10:25 A.M.. The review indicated the client's most current Comprehensive Functional Assessment was dated 1/20/11.</p> <p>Program Director #1 was interviewed on 5/22/12 at 11:07 A.M.. Program Director #1 indicated the most current Comprehensive Functional Assessments for clients #1, #2, #3, and #4 were reviewed on 1/20/11.</p> <p>9-3-4(a)</p>				

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W0262	<p><b>483.440(f)(3)(i)</b> <b>PROGRAM MONITORING &amp; CHANGE</b> The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>Based on interview and record review the facility's specially constituted committee failed to review, approve and ensure a behavior plan was updated to include all behavior altering medication prescribed. This affected 1 of 2 clients in the sample, (client #1).</p> <p>Findings include:</p> <p>During record review for Client #1 on 5/22/12 at 9:30 AM physician orders dated 5/15/12 were present prescribing the following behavior altering medications. Benzotropine 2 milligrams BID (twice daily); Depakote ER (extended release) - 500 milligrams in AM; Quetiapine 400 milligrams at HS; Invega sustena IM (intra-muscular) every four weeks (medications used to control maladaptive behaviors).</p> <p>Review of Client #1's behavior support plan with an implementation date of</p>	W0262	<p><b>W262 Program Monitoring and Change</b> The Program Director/QMRP will be retrained on assuring that the Dungarvin Human Rights Committee approves any changes related to increases in behavioral medications that are restrictive in nature for any of the individuals at the ESN1 home. Quarterly, Program Director/QMRP's will conduct audits of the client files. This audit will include assuring that approvals by the Human Rights Committee are made based on identified need for any restrictions including medications. These audits will be reviewed by the Program Coordinator for follow up assurance. System wide, all Program Director/QMRP's will review this standard and the need to assure that this concern is being addressed at all Dungarvin ICF-MR's.</p> <p><b>Completion Date: 6-24-12</b> <b>Persons Responsible: Program Director/ QMRP, Program Coordinator</b></p>	06/24/2012			

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	<p>6/21/10 and last reviewed by the facility's Human Rights Committee (HRC) on 8/9/11, indicated the HRC had also reviewed Client #1's accompanying " Psychotropic Medication Treatment Plan. " The plan dated 6/22/10 referenced the use of Divalproex Sod ER, Clonazepam, Seroquel and Propranolol for Intermittent Explosive Disorder and Personality Disorder. There was no reference to the use of Invega Sustena IM.</p> <p>Further record review indicated Client #1 went to the psychiatrist for the first " loading dose " of intra-muscular Invega Sustena on 3/25/12.</p> <p>Program Director #1 was interviewed on 5/22/12 at 1:00 PM to ascertain if the facility's HRC had reviewed an updated behavior program incorporating the use of Invega Sustena IM, the Program Director indicated the HRC had not reviewed or approved any update since the behavior plan had not yet been revised to include the new medication.</p> <p>9-3-4(a)</p>						

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W0263	<p>483.440(f)(3)(ii) <b>PROGRAM MONITORING &amp; CHANGE</b> The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on interview and record review, the facility 's specially constituted committee failed to ensure written consent was obtained for one behavior altering medication prior to initiation. This affected one of two clients in the sample (client #1).</p> <p>Findings include:</p> <p>During record review for Client #1 on 5/22/12 at 9:30 AM physician orders dated 5/15/12 were present prescribing the following behavior altering medications. Benztropine 2 milligrams BID (twice daily); Depakote ER (extended release) - 500 milligrams in AM; Quetiapine 400 milligrams at HS (hour of sleep); Invega sustena IM (intra-muscular) every four weeks (medications used to control maladaptive behaviors). Additional record review indicated Client #1 went to the psychiatrist for the first " loading dose " of intramuscular Invega Sustena on</p>	W0263	<p><b>W263 Program Monitoring and Change</b> The Program Director/QMRP will be retrained on assuring that the Dungarvin Human Rights Committee approves any changes related to increases in behavioral medications that are restrictive in nature for any of the individuals at the ESN1 home, only after written informed consent is obtained by the individual if emancipated, or their parent/guardian. Quarterly, Program Director/QMRP's will conduct audits of the client files. This audit will include assuring that approvals by the Human Rights Committee and the individual if emancipated or their legal guardians are obtained based on identified need for any restrictions including medications. These audits will be reviewed by the Program Coordinator for follow up assurance. System wide, all Program Director/QMRP's will review this standard and the need to assure that this concern is being addressed at all Dungarvin ICF-MR's. <b>Completion Date: 6-24-12</b> <b>Persons Responsible:</b> <b>Program Director/ QMRP,</b> <b>Program Coordinator</b></p>	06/24/2012	

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	<p>3/25/12, however no consent for this medication was evident in the record.</p> <p>Review of the Human Rights Committee " Signatures of Approval " form associated with Client #1's BSP (behavior support plan) documented a review of the BSP dated 6/10/10 that incorporated the use of Seroquel, Depakote, Propranolol and Benzotropine. This was evident via signatures from HRC members that were dated 8/9/11. Further review indicated client #1 did give written approval for the use of the aforementioned medications.</p> <p>Program Director was interviewed on 5/22/12 at 1:00 PM to ascertain if consent had ever been obtained from Client #1 and his Health Care Representative for Invega Sustena IM. Program Director #1 indicated no such written consent had been obtained.</p> <p>9-3-4(a)</p>				

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W0264	<p>483.440(f)(3)(iii) <b>PROGRAM MONITORING &amp; CHANGE</b> The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.</p> <p>Based on observation, record review and interview, the facility's Human Rights Committee failed to monitor the use of door alarms for 4 of 4 clients living in the group home (clients #1, #2, #3, and #4).</p> <p>Findings include:</p> <p>Clients #1, #2, #3, and #4 were observed at the group home during the 5/21/12 observation period from 4:35 P.M. until 7:15 P.M., and on 5/22/12 from 6:00 A.M. until 8:15 A.M.. During both observations a door alarm would sound when clients #1, #2, #3, and #4 used to doors to enter or exit the facility.</p> <p>Direct care staff #1 was interviewed on 5/22/12 at 8:17 A.M.. Direct care staff #1 stated, "The door alarms sound to alert staff when clients enter or leave the group home."</p> <p>Human Rights Committee records from</p>	W0264	<p><b>W264 Program Monitoring and Change</b> The Program Director/QMRP will be retrained on assuring that the Dungarvin Human Rights Committee is asked to review the use of door alarms for all individuals that have elopement as an assessed need. The HRC will also review the use of these alarms for men living at this home that do not have elopement as an assessed need but do have approval from their IDT's and legal guardians to use them in the home as a safety measure.</p> <p>Quarterly, Program Director/QMRP's will conduct audits of the client files. This audit will include assuring that approvals by the Human Rights Committee are made based on identified need for any restrictions. These audits will be reviewed by the Program Coordinator for follow up assurance.</p> <p>System wide, all Program Director/QMRP's will review this standard and the need to assure that this concern is being addressed</p>	06/24/2012

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	<p>5/21/11 to 5/21/12 were reviewed on 5/22/12 at 9:22 A.M.. The review failed to indicate the facility's Human Rights Committee reviewed the practice of door alarms on all exit doors of the facility which affected clients #1, #2, #3, and #4 who live at the facility.</p> <p>Program Coordinator #1 was interviewed on 5/22/12 at 9:33 A.M.. Program Coordinator #1 indicated the facility's Human Rights Committee did not review the use of door alarms at the facility which affected clients #1, #2, #3, and #4.</p> <p>9-3-4(a)</p>		<p>at all Dungarvin ICF-MR's. <b>Completion Date: 6-24-12</b> <b>Persons Responsible: Program Director/ QMRP, Program Coordinator</b></p>		