

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/12/2011
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 1222 N BOLTON AVE INDIANAPOLIS, IN46219
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W0000	<p>This visit was for investigation of complaint #IN00097770.</p> <p>Complaint #IN00097770: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W104, W149, W153, W189, W240 and W331.</p> <p>Unrelated deficiencies cited.</p> <p>Dates of Survey: 10/4, 10/5, 10/6 and 10/12/11</p> <p>Facility Number: 001008 Provider Number: 15G494 AIMS Number: 100245080</p> <p>Surveyor: Paula Chika, Medical Surveyor III-Team Leader</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/25/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
W0104	<p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (A), the governing body failed to exercise</p>	W0104	CORRECTION: <i>The Governing body must exercise general policy, budget and operating</i>	11/11/2011

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

TITLE

(X6) DATE

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

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	<p>general policy, budget and operating direction over the facility to ensure measures/supports (staffing, training, monitoring, behaviorist etc...) were put in place to assist the client to be successful in his current placement.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 10/4/11 at 12:28 PM. The facility's reportable incident reports/investigations indicated the following:</p> <p>-10/3/11 "During an investigation regarding a previously reported incident, [client A] alleged that [staff #6] ripped his shirt and encouraged his housemates to fight with him."</p> <p>-9/30/11 "[Client A's] mother reported that while he was visiting her, [client A] alleged that staff [staff #1] took his keys from him and that staff [staff #7] encouraged his housemates to assault him physically."</p> <p>-9/28/11 client A was upset over restrictions (not able to ride bike) put in place by his interdisciplinary team (IDT) due to a recent elopement. The reportable incident report indicated "...He told staff he was going for a walk and immediately</p>		<p><i>direction over the facility.</i></p> <p>Specifically, The agency will oversee the coordination of appropriate resources to support Client A through his transition into his new SGL residence. The QDDPD will work with the agency's behavioral clinician to update Client A's Functional Behavioral Assessment to assist with development of a Behavior Support Plan that addresses Client A's Current Behavioral needs. Professional and Direct Support staff will be retrained on agency approved behavior management techniques (You're Safe, I'm Safe) with emphasis on proper implementation of Client A's revised behavior supports. Additionally, the QDDPD is directing the team to update Client A's comprehensive functional assessment to assist with development of an updated individual support plan that addresses Client A's current developmental and socialization needs. The QDDPD will assure all direct support staff are trained on implementation of Client A's revised ISP. PREVENTION: Professional staff will be retrained regarding the need to mentor all team members toward being personally invested in the success of all clients, with emphasis on individuals who are new to the facility. Members of the Operations Team will maintain an increased presence in the house to monitor the</p>		

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	<p>exited through the home's unlocked front door. Staff accompanied him within line of sight, per his plan for 10 minutes and then [client A] ran out of sight. Staff initiated a search of the neighborhood and located him at the library 10 minutes later. Staff remained with [client A] at the library until he eluded them again at 4:30 PM. Staff continued to look for [client A] until 5:20 PM when a missing persons report was filed with the police per his BSP (Behavior Support Plan). Police located him within 20 minutes and he returned with staff to his SGL (Supervised Group Living) residence. He remained in his neighborhood and did not present a significant danger to himself or others while he was away from staff supervision. [Client A] remained agitated through the evening and night, yelling and threatening staff, and throwing cans of food at staff at regular intervals. Staff efforts at redirection were unsuccessful through the night. When asked to take his 6 AM medication, [client A] resumed yelling, using profanity and throwing items. Staff attempted to redirect him to a quiet area to calm himself without success. The supervisor arrived and joined the team's efforts to encourage [client A] to take his morning medication. He continued to yell and punched his window, causing it to break. As [client A] continued to escalate, staff called the police and they</p>		<p>training environment and provide hands-on coaching of direct support staff, while Client A continues to adjust to his new residential setting. In the long term, members of the Operations Team will perform periodic document reviews and active treatment observations to assure continuity of supports for all clients/ Responsible Parties: QDDPD, Support Associates, Behavior Consultant, Operations Team</p>		

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	<p>transported him to [name of hospital] for an emergency psychiatric evaluation. [Client A] was assessed and released with no recommendations...."</p> <p>-9/22/11 "[Client A] was riding his bike on Bolton Road within the parameters of his Individual Support Plan (ISP), which states that he will remain in line of sight of his house and staff will observe him at intervals. At 5:45 PM staff noted that [client A] was no longer in sight of the residence. Staff initiated a search of the area and when staff could not locate him after two hours, they called the police per the elopement protocol in [client A's] Behavior Support Plan. Police located [client A] in [name of town in Indiana] at 10:10 PM. Although [client A] is assessed as being able to ride his bike in the community, the team agrees he was a danger to himself at the time of the incident. He was transported to [name of hospital] for a psychiatric evaluation and he was released at 4:30 AM, with no recommendations. Upon returning home he obtained a pair of scissors and began attempting to cut himself. He walked out of the unlocked front door of the house and staff followed keeping him in line of sight. Staff attempted to redirect him to return home but her (sic) refused saying he needed help. He walked ahead of staff to [name of hospital] and requested an</p>			

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	<p>evaluation. [Name of hospital] transferred [client A] to [name of psychiatric hospital], where he was released to SGL staff at 2:00 PM....."</p> <p>During the 10/4/11 observation period between 3:00 PM to 5:38 PM, at the group home, staff #2, #4 and #8 worked with client A. Client A attempted to interact with staff. Staff limited their contact/interactions with the client as staff only answered the client's question in a quick manner and/or ignored the client. At one point, client A asked staff #2, #4 and #8, who were in the living room, what would happen if he flattened a tire for an April's fool joke. The staff did not redirect and/or acknowledge the client. Client A then made a statement about causing harm to a teacher. Staff #2, #4 and #8 did not redirect and/or acknowledge the client as the staff ignored the client versus ignoring the client's behavior.</p> <p>Client A's record was reviewed on 10/5/11 at 10:37 AM. Client A's Progress Notes indicated the following (not all inclusive):</p> <p>-9/29/11 (6 AM to 2 PM) client A was verbally aggressive toward staff and threw different objects at staff. The progress note indicated "...Another consumer got</p>				

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	<p>agitated with [client A] and tried (sic) to attack [client A]...." A second 9/29/11 note indicated client A threw keys at staff and threw items around in his bedroom.</p> <p>-9/28/11 (2 PM to 10 PM) client A threatened "to trash house...." The note indicated client A threw the phone at staff and "Staff put the phone away so he wouldn't throw it again. So, [client A] went in the kitchen and started throwing cans and started yelling and cussing...." The progress note indicated client A threw his juice, fruit and water at the other clients at the table. The 9/28/11 progress note indicated client A threw hand sanitizer and the remote at staff as well, and threatened to throw a pitcher of water at staff.</p> <p>-9/28/11 (6 AM to 2 PM) client A threw milk in a peer's face.</p> <p>-9/25/11 client A threatened to throw items at staff.</p> <p>-9/21/11 client A came from the back of the group home throwing items (dish soap) at the other clients causing them to become agitated. The progress note indicated YSIS (Your Safe I'm Safe-behavior management technique) was done and then the client began to target the staff. The progress note</p>				

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	<p>indicated client A had thrown the dish soap all over the floor and walls.</p> <p>-9/10/11 the library called and asked staff to come and pick up client A. The note indicated client A became upset (verbal and loud) at the library when the library staff redirected the client from using 2 computers at the same time. The note indicated the library staff indicated client A could not return to the library for that week.</p> <p>-9/7/11 (6 AM to 2 PM) client A refused his medications, cursed and yelled at other clients and staff, and threw things at staff and the clients.</p> <p>-9/7/11 (10:30 AM) staff was in kitchen putting groceries away when client A came into the kitchen and started throwing a water bottle at staff, became verbally aggressive and agitated the other clients in the home.</p> <p>-9/3/11 client A was throwing items and cussing at staff. Client caused other clients to "become agitated."</p> <p>-9/2/11 client A threatened to go AWOL (absence without leave), threatened staff and was attacked/bitten by his roommate (client C).</p>				

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	<p>Client A's 9/19/11 psychiatric Record Of Visit form indicated client A was "Transitioning to new Group Home well, although w/ (with) occasional periods of irritability."</p> <p>Client A's IDT meeting notes indicated the following (not all inclusive):</p> <p>-8/22/11 client A moved into the group home on 8/20/11 from another Voca group home. The note indicated client A would be allowed to ride his bike on Bolton Road. The note indicated client A would be allowed to go to the library alone one time a week for up to 3 hours. The note indicated the IDT would meet in 30 days to re-evaluate the client's community access.</p> <p>-9/22/11 "[Client A] will continue to just ride from 16th street to 10th street on Bolton for 2 hours due to safety reasons. [Client A] has agreed to go to the library on Monday and Tue (Tuesday) from 12pm to 3pm, Thurs (Thursday) from 4pm to 8pm. [Client A] wants to learn how to take his meds independently- he wants to punch out his 9pm meds daily. [Client A] wants to prepare his own breakfast & (and) lunch daily and assist with dinner 3 x (times) weekly."</p> <p>-9/29/11 meeting held to discuss client A</p>				

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	<p>walking off from the group home and the police having to become involved to find him. The note indicated client A would be allowed to walk on Bolton road when he asked staff but he would have to stay in the line of sight of staff. An attached undated typed note indicated "Team has come to agreement that [client A] will not have Alone time/Biking Riding (sic) until further notice, from incident on 9/22/11...."</p> <p>Client A's 12/5/10 ISP indicated the client had lived at 2 previous group homes within the agency (Voca/Res-care) since 6/4/09. Client A's 12/15/10 ISP indicated client A lived at a Voca group home from 6/4/09 to 11/5/10 before moving to another Voca group home from 11/5/10 to 8/20/11. Client A's 12/15/10 ISP indicated the client lived in a group home with another facility/agency from 2/06 to 12/1/07.</p> <p>Client A's 1/6/11 Person Centered Planning Profile indicated "...[Client A] continues to require ICF/MR level of care and active treatment due to the fact that [client A] lacks the ability to transfer some skills to other environments or settings, is unable to conduct himself appropriately and safely when allowed to have alone time away from the home, and is unable to provide basic health, safety</p>				

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	<p>and nutritional needs without continuous supervision, training and staff support...."</p> <p>Client A's 7/15/11 Behavior Support Plan (BSP) indicated the client demonstrated harassing others, verbal aggression, physical aggression, elopement, attention seeking behavior and suicidal ideation. Client A's 7/15/11 BSP indicated the client demonstrated verbal aggression, physical aggression, harassing others, threats to harm self, non-compliance, taking keys to work, stealing keys and elopement with his previous placements. Client A's 12/5/10 ISP and/or 7/15/11 Behavior Support Plan did not indicate the governing body put in place any additional supports and/or measures ensure/assist client A to be successful with his current group home placement.</p> <p>Interview with client G on 10/4/11 at 5:25 PM indicated client A had thrown water on client F.</p> <p>Confidential staff interview A stated client A has "high social skills but can't control his behaviors and treat people the way he wants to be treated." Confidential staff interview A stated client A was "not doing good." Confidential interview A indicated client A would throw items at others, refused medications, and demonstrated attention seeking behavior.</p>						

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	<p>Confidential interview A stated "The same behaviors have followed him in all the other group homes. Not good for other clients. They are picking up on his bad habits." Confidential staff interview A stated "He (client A) is an antagonist." Confidential interview A indicated client would throw water on the other clients and staff. Confidential staff interview A further stated "I'm frustrated. Don't know what to do. I can't watch him and the other clients. He needs to know his limitations. His behaviors supercedes any positive thing." Confidential interview A stated "He needs consequences. He is not the right fit for the home." Confidential interview A stated the other clients in the group home "They put up with him."</p> <p>Confidential staff interview B indicated client A would throw things, pour and throw pitchers of water at others. Confidential interview B stated client A would "target" other clients who would not respond or retaliate. Confidential staff interview B indicated the clients were ok with client A until he started to throw things. Confidential interview B indicated client A was not appropriate for the group home due to his behaviors. Confidential interview B indicated clients C and F were getting tired of client A's throwing items at them and others.</p>				

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	<p>Confidential staff interview C indicated client A would throw items at others and then run. Confidential interview C indicated other clients in the group home indicated they did not like client A. Confidential interview C stated "He (client A) knows we can't put our hands on him. He will do things and then laugh in our face." Confidential interview C indicated client C could not ride his bike safely as the police almost ran over him when he eloped from the group home. Confidential staff interview C stated "He is more intelligent than the other clients. He thinks he knows everything."</p> <p>Confidential staff interview D indicated client A should not be at the group home. Confidential staff interview D stated "I feel he is too high functioning to be here. Agitating clients. Very manipulative and causing other behaviors." Confidential interview D indicated client A had not been successful with any group home placement.</p> <p>Confidential staff interview E stated "[Client A] does not want to be here. He has been to 3 to 4 different group homes. He is not working out anywhere." Confidential interview E indicated client A would elope from the group home, threaten staff and clients and would throw things at others. Confidential interview E</p>			

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	<p>indicated client A would call the office on the staff at the group home whenever they did not let him have his way. Confidential interview E stated "We (staff) would get in trouble." Confidential interview E indicated client A did not have any consequences for his behavior. Confidential staff interview E stated "He knows what he is doing when he acts out." Confidential interview E indicated client A's behavior plan had no effect on the client's behavior.</p> <p>Confidential staff interview F indicated client A would throw objects at staff, clients and poured milk on clients as they sat on the couch. Confidential interview F indicated client A's behaviors were preventing the client from living in a less restrictive environment.</p> <p>Interview with administrative staff #3 on 10/5/11 at 11:20 AM indicated client A had lived in 2 of their other group homes prior to being moved to Bolton. Administrative staff #3 indicated client A had not had success with his other placements due to his aggression/behaviors. Administrative staff #3 indicated client A's mother lived in another state and client A wanted to move/live in his home town. Administrative staff #3 indicated the facility had been looking for an alternate</p>				

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W0149	<p>placement in his home town with no success. Administrative staff #3 indicated he (administrative staff #3) met with facility staff last week and they did not indicate they had any concerns with working with client A at that time. Administrative staff #3 indicated the staff would be transferred if they could not work with the client. Administrative staff #3 indicated 3 staff were currently on suspension for allegations of abuse. When asked how often the administrative staff visited the group home, administrative staff #3 stated "Two times a month." Administrative staff #3 did not indicate the facility put in place any additional measures/supports to ensure the client's success with his current placement.</p> <p>This federal tag relates to complaint #IN00097770.</p> <p>9-3-1(a)</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, interview and record review for 3 of 4 sampled clients (A, C and D), the facility failed to implement its policy and procedures in regard to reporting all allegations of abuse, injuries of unknown origin</p>	W0149	CORRECTION: <i>The facility must develop and implement written policies and procedures that prohibit mistreatment, abuse or neglect of the client. Specifically, a report will be made to the Division of Disability and Rehabilitation Services and Adult</i>	11/11/2011	

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	<p>immediately to the administrator and/or to state officials. The facility failed to implement its policy and procedures to conduct through investigations in regard to incidents of client to client aggression/abuse.</p> <p>Findings include:</p> <p>The facility's policy and procedures were reviewed on 10/5/11 at 3:20 PM. The facility's 9/14/07 policy entitled Abuse, Neglect, Exploitation indicated "Adept employees actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect and exploitation shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of Adept, Rescare, local, state and federal guidelines." The 9/14/07 policy indicated "...3. Any employee who suspects an individual is the victim of abuse, neglect or exploitation will immediately notify the Program Director (PD) Director of Operations and Director of Quality Assurance who will then begin the investigation process. The Executive Director and the Regional Director will also be notified...." The facility's 9/14/07 policy indicated allegations of abuse, neglect and incidents of injuries of unknown origin would be investigated.</p>		<p>Protective Services regarding an incident of aggression between Client's A and C that occurred on 9/2/11 and facility professional staff will receive performance action and retraining in response to failing to report Client A's injury of unknown origin discovered on 9/30/11. Additionally, the Operations Team will review agency investigation expectations with Client C and D's day service provider to assure all incidents of client to client aggression are investigated thoroughly and the results of investigations are reported to the facility.</p> <p>PREVENTION: The facility will send copies of internal incident reports to the administrator via electronic fax upon completion, to assure the operations team has the ability to report incidents to state agencies as required, in a timely manner. In addition, facility professional staff will follow-up with day service providers after incidents of client to client aggression occur, to assure that appropriate day service personnel investigate the incidents in a thorough and timely manner. Members of the Operations Team will compare internal incident reports to the agency's incident tracking log to assure incidents are reported as required, and on an ongoing basis, members of the Operations Team will perform periodic reviews of day service incident reports and accompanying documentation to</p>		

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W0153	<p>1. The facility failed to ensure facility staff reported an allegation of abuse/injury of unknown origin immediately to the administrator regarding client A. The facility failed to ensure the facility reported an incident of client to client aggression/abuse involving clients A and C to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b)(5) and to Adult Protective Services (APS) per IC 12-10-3. Please see W153.</p> <p>2. The facility failed to conduct thorough investigations involving client to client abuse/aggression incidents for clients C and D. Please see W154.</p> <p>This federal tag relates to complaint #IN00097770.</p> <p>9-3-2(a)</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on observation, interview and record review for 2 of 16 allegations of abuse, neglect and/or injuries of unknown origin reviewed, the facility failed to</p>	W0153	<p>assure investigations occur as required. Responsible Parties: QDDPD, Support Associates, Day Service Administrators, Operations Team</p> <p>CORRECTION: <i>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source are reported immediately</i></p>	11/11/2011	

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	<p>ensure facility staff reported an allegation of abuse/injury of unknown origin immediately to the administrator regarding client A. The facility failed to ensure the facility reported an incident of client to client aggression/abuse involving clients A and C to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b)(5) and to Adult Protective Services (APS) per IC 12-10-3.</p> <p>Findings include:</p> <p>1. During the 10/4/11 observation period between 5:40 AM and 8:15 AM, at the group home, client A had a large (4 to 5 inch) fading yellow bruise to the back of his right upper arm which was circular in shape. Client A also had a thumb print size circular black bruise on his upper right inner arm. Interview with client A on 10/4/11 at 7:30 AM indicated facility staff caused the bruise on his arm. Client A stated he reported the injury to his mother and staff at the facility "last week."</p> <p>During the 10/4/11 observation period between 3:00 PM and 5:38 PM, at the group home, client A showed staff #2 his right arm. When staff #2 asked client A how he received the injury, client A stated "First shift staff did it." Interview with</p>		<p><i>to the administrator or to other officials in accordance with state law through established procedures.</i> Specifically, a report will be made to the Division of Disability and Rehabilitation Services and Adult Protective Services regarding an incident of aggression between Client's A and C that occurred on 9/2/11. Additionally, facility professional staff will receive performance action and retraining in response to failing to report Client A's injury of unknown origin discovered on 9/30/11. PREVENTION: The facility will send copies of internal incident reports to the administrator via electronic fax upon completion, to assure the operations team has the ability to report incidents to state agencies as required in a timely manner. Members of the operations team will compare internal incident reports to the agency's incident tracking log to assure incidents are reported as required. Responsible Parties: QDDPD, Support Associates, Operations Team</p>		

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	<p>staff #2 on 10/4/11 at 3:27 PM indicated she was not aware of the bruise until now. Staff #2 stated "He did not tell us (evening shift staff)."</p> <p>Client A's record was reviewed on 10/5/11 at 10:37 AM. Client A's Progress Notes indicated the following:</p> <p>-9/30/11 "5:30 PM [Client A] showed (R) (right) arm to his mother said that a staff had did it. Bruised on his (R) arm-to her it didn't look like a rash to her. She (client's mother) stated it look like a bruise that was going away. She took picture of it. [Staff #1] showed her the picture that was taken earlier with red bumps on it. Bumps had went, but still red (sic)."</p> <p>-10/2/11 on the 10 PM to 8 AM, shift, "... [Client A] said he had a bruise on him. [Client A] said he didn't know how he got the bruise then he said he was scrached (sic)...."</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 10/4/11 at 12:28 PM. The facility's reportable incident reports from 5/11 to 10/11 indicated client A's allegation of abuse/injury of unknown origin had not been immediately reported to the administrator and/or to BDDS.</p>			

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	<p>Interview with administrative staff #2 on 10/5/11 at 12:30 PM indicated he was notified by e-mail on 10/4/11 of client A's injury of unknown origin/allegation of abuse. Administrative staff #2 indicated he was not notified on 9/30/11 and/or on 10/2/11 by facility staff.</p> <p>Interview with administrative staff #1 (administrator) on 10/5/11 at 1:00 PM indicated she was not made aware of client A's allegation of abuse/injury until today 10/5/11.</p> <p>2. The facility's reportable incident reports and/or investigations were reviewed on 10/4/11 at 12:28 PM. The facility's 9/2/11 internal Incident/Accident Report (IAR) indicated client C "attacked" client A when they were in their bedroom. The facility's internal IAR and investigation indicated client C bit client A on the arm as client C was ready to go to work and client A would not get up. The facility's 9/2/11 investigation indicated "...[Client A] had some red welts on his left arm."</p> <p>The facility's reportable incident reports from 5/11 to 10/11 indicated the facility did not report the client to client aggression/abuse to BDDS per state law.</p>				

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W0154	<p>Interview with administrative staff #2 on 10/5/11 at 12:30 PM indicated he was not able to locate the reportable incident report for the 9/2/11 incident between clients A and C. Administrative staff #2 stated "Can't imagine not reporting." Administrative staff #2 indicated administrative staff #1 was not able to locate a report as well. Administrative staff #2 indicated the client to client abuse/incident should have been reported.</p> <p>This federal tag is related to complaint #IN00097770.</p> <p>9-3-2(a)</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 2 of 16 allegations of abuse, neglect and/or injuries of unknown origin reviewed, the facility failed to conduct thorough investigations involving client to client abuse/aggression incidents for clients C and D.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 10/4/11 at 12:28 PM. The facility's reportable incident reports indicated the following:</p>	W0154	<p>CORRECTION: <i>The facility must have evidence that all alleged violations are thoroughly investigated.</i> Specifically, the Operations Team will review agency investigation expectations with Client C and D's day service provider to assure all incidents of client to client aggression are investigated thoroughly and the results of investigations are reported to the facility.</p> <p>PREVENTION: Facility professional staff will follow-up with day service providers after incidents of client to client aggression occur to assure that appropriate day service personnel investigate the incidents in a</p>	11/11/2011			

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W0189	<p>-6/21/11 "[Client C] got into an altercation with another consumer at work and bit the consumer on the arm." The 6/21/11 reportable incident report did not indicate any additional information and/or documentation of an investigation.</p> <p>-6/14/11 client D scratched a female peer at work after client D indicated he was hit by the client. The 6/14/11 reportable incident report did not indicate any additional information and/or documentation of an investigation in regard to the alleged client to client incident.</p> <p>Interview with administrative staff #2 on 10/5/11 at 12:30 PM indicated they were not able to locate any additional documentation of an investigation for the client to client incidents.</p> <p>9-3-2(a)</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on interview and record review for 1 of 4 sampled clients (A), the facility failed to ensure all staff had been trained in the facility's behavioral/physical intervention techniques of YSIS (Your</p>	W0189	<p>thorough and timely manner. On an ongoing basis, members of the Operations Team will perform periodic reviews of day service incident reports and accompanying documentation to assure investigations occur as required. Responsible Parties: QDDPD, Support Associates, Day Service Administration, Operations Team</p> <p>CORRECTION: <i>The facility must provide each employee with initial and continuing training that enables the employees to perform his or her duties effectively, efficiently, and competently. Specifically, facility</i></p>	11/11/2011	

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	<p>Safe, I'm Safe).</p> <p>Findings include:</p> <p>Client A's record was reviewed on 10/5/11 at 10:37 AM. Client A's 9/21/11 Progress Note indicated "One of [client A's] walk into the restroom while he was in there (sic). [Client A] came from the back of the group home yelling and throwing house items at the other consumers agitating them...[Client A] continued to target the consumers. When staff blocked [client A] he targeted staff. Staff did I'm Safe Your Safe. [Client A] Sliped (sic) on the dish soap that he throw that burst all over the kitchen, by the front door and all on the walls...."</p> <p>Client A's 7/15/11 Behavior Support Plan (BSP) indicated facility staff could use YSIS techniques of blocking and physical escort to move the client when he demonstrated physical aggression toward others.</p> <p>The facility's training records were reviewed on 10/5/11 at 1:00 PM. The facility's YSIS inservice training records for 3/24/11 indicated staff #2 and staff #9 had not received the YSIS training.</p> <p>Interview with administrative staff #3 on 10/5/11 at 1:05 PM indicated staff #2 and</p>		<p>staff will be retrained on implementation of agency approved behavior management techniques (You're Safe,I'm Safe) with emphasis on incorporating them into the development of effective approaches with clients who reside at the facility. PREVENTION: The agency's Staff Development Coordinator will maintain training records of all facility staff and will inform facility professional staff and the Operations Team when staff are due for annual re-certification.Facility Professional staff will arrange for training sessions to assure that all staff maintain current You're Safe, I'm Safe certification. Responsible Parties: QDDPD, Support Associates, Staff Development Coordinator, Operations Team</p>		

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W0227	<p>#9 had not received the YSIS training.</p> <p>This federal tag relates to complaint #IN00097770.</p> <p>9-3-3(a)</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview and record review for 1 of 4 sampled clients (A), the facility failed to address the client's identified behavioral and/or training needs.</p> <p>Findings include:</p> <p>1. During the 10/4/11 observation period between 5:40 AM and 8:15 AM, at the group home, client A left with the other clients to drop them off the day program/workshop and then returned to the group home. Interview with staff #3 on 10/4/11 at 6:40 AM indicated client A did not attend a day program and/or workshop due to the client's aggressive behavior.</p> <p>During the 10/4/11 observation period between 3:00 PM and 5:38 PM, at the group home, client A was at the group home when the surveyor arrived at 3:00</p>	W0227	<p>CORRECTION: <i>The Individual Program Plan states the specific objectives necessary to meet the client's needs as identified by the comprehensive assessment. Specifically for Client A, the interdisciplinary team is completing reassessments and will create an updated Individual Support Plan and Behavioral Support Plan that addresses Client A's current developmental, socialization and behavioral needs. Direct support staff will be trained on proper implementation of these new plans.</i></p> <p>PREVENTION: Professional staff will be retrained on the transition process for new clients with focus on the need to develop modified supports to help clients adjust to new residential environments and the need to pull all members and resources of the team together to develop appropriate and functional supports. Members of the Operations Team will review support documents when new</p>	11/11/2011	

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	<p>PM. Interview with client A on 10/4/11 at 3:05 PM indicated he did not attend a day program and/or workshop.</p> <p>Client A's record was reviewed on 10/5/11 at 10:37 AM. Client A's 12/5/10 Individual Support Plan (ISP) did not indicate what training should occur with the client during the day.</p> <p>Interview with staff #5 on 10/5/11 at 9:37 AM stated client A "slept" during the day on 10/4/11. Staff #5 indicated client A did not go to a day program and/or workshop.</p> <p>Interview with administrative staff #3 on 10/5/11 at 11:20 AM indicated client A moved to the group home on 8/20/11. Administrative staff #3 indicated client A did not attend a day program and/or workshop. Administrative staff #3 stated he thought a "schedule" had been put in place for client A during the day. Administrative staff #3 indicated the schedule would indicate what training was to be done with the client. Administrative staff #3 was not able to locate the schedule/training.</p> <p>2. The facility's reportable incident reports were reviewed on 10/4/11 at 12:28 PM. The facility's 9/29/11 reportable incident report indicated client A refused</p>		clients move into the facility to assure they address currently assessed needs. Responsible Parties: QDDPD, Support Associates, Behavior Consultant, Operations Team		

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	<p>to take his morning medications on 9/29/11.</p> <p>Client A's record was reviewed on 10/5/11 at 10:37 AM. Client A's Progress Notes indicated client A refused to take his medications on 9/28/11, 9/24/11 and 9/7/11.</p> <p>Client A's 9/19/11 physician's orders indicated the client received Zoloft 100 milligrams 2 times a day and Buspar 20 milligrams three times a day for behavior. Client A's 7/18/11 physician's order indicated the client also received Docusate Sodium 100 milligrams daily for constipation, Synthroid 50 mcg daily for Hypothyroidism, Claritin 10 milligrams daily for allergies, Melatonin 3 milligrams for Insomnia, Prilosec 20 milligrams for Gastroesophageal Reflux Disorder, K-Dur 10 meq daily for potassium supplement, Naprosyn 500 milligrams daily for headaches, and Inderal 10 milligrams twice daily for behavior.</p> <p>Client A's 8/22/11 Interdisciplinary Team meeting (IDT) note, 9/22/11 IDT note, 9/29/11, IDT note, 12/5/10 ISP and or 7/15/11 Behavior Support Plan (BSP) did not specifically address client A's medication refusals.</p>				

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W0240	<p>Interview with administrative staff #3 on 10/5/11 at 11:20 AM indicated he thought client A's medication refusals had been addressed by the client's IDT.</p> <p>9-3-4(a)</p> <p>The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on interview and record review for 1 of 4 sampled clients (A), the client's Individual Support Plan (ISP) failed to indicate how facility staff were to assist the client to feel safe/comfortable in his home, and/or to tell staff how to handle/prevent the client's throwing water/fluids on others.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports and/or investigations were reviewed on 10/4/11 at 12:28 PM. The facility's 9/2/11 internal Incident/Accident Report (IAR) indicated client C "attacked" client A when they were in their bedroom. The facility's internal IAR and investigation indicated client C bit client A on the arm as client C was ready to go to work and client A would not get up. The facility's 9/2/11 investigation indicated "...[Client A] had some red welts on his left arm." The facility's</p>	W0240	<p>CORRECTION: <i>The Individual Program Plan must describe relevant interventions to support the individual toward independence.</i> Specifically for Client A, the interdisciplinary team is completing reassessments and will create an updated Individual Support Plan and Behavioral Support Plan that addresses Client A's current developmental, socialization and behavioral needs. Direct Support Staff will be trained on proper implementation of these new plans. Members of the operations Team will maintain an increased presence in the facility as Client A continues to adjust to his current residence to assure a safe and comfortable environment. PREVENTION: Professional staff will be retrained on the transition process for new clients with focus on the need to develop modified supports to help clients adjust to new residential environments and the need to pull all members and resources of the team together to develop appropriate and functional</p>	11/11/2011	

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	<p>9/2/11 IAR witness statement for client A indicated "[Client A] stated he was scared for his life, he not safe living here and whats to move (sic)."</p> <p>Interview with client A on 10/4/11 at 7:20 AM indicated client C was his roommate. Client A indicated client C bit him one time and he did not want client C to hit or bite him again. Client A stated "I have to watch my back with him."</p> <p>Client A's record was reviewed on 10/5/11 at 10:37 AM. Client A's 12/5/10 Individual Support Plan (ISP) did not indicate the client's interdisciplinary team addressed client A's statement in the 9/2/11 client to client incident. Client A's 12/15/10 ISP and/or BSP did not indicate how facility staff were to assist the client to feel safe and/or comfortable in his environment.</p> <p>Interview with administrative staff #3 on 10/5/11 at 3:15 PM indicated he was not aware of the 9/2/11 incident between clients A and C. Administrative staff #3 indicated client A's IDT should have addressed client A's statement.</p> <p>2. Client A's record was reviewed on 10/5/11 at 10:37 AM. Client A's Progress Notes indicated the following (not all inclusive):</p>		<p>supports. Members of the Operations Team will review support documents when new clients move into the facility to assure they address currently assessed needs. Responsible Parties: QDDPD, Support Associates, Behavior Consultant, Operations Team</p>		

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	<p>-9/29/11 (6 AM to 2 PM) client A was verbally aggressive toward staff and threw different objects at staff. A second 9/29/11 note indicated client A threw keys at staff and threw items around in his bedroom.</p> <p>-9/28/11 (2 PM to 10 PM) client A threatened "to trash house...." The note indicated client A threw the phone at staff and "Staff put the phone away so he wouldn't throw it again. So, [client A] went in the kitchen and started throwing cans and started yelling and cussing...." The progress note indicated client A threw his juice, fruit and water at the other clients at the table. The 9/28/11 progress note indicated client A threw hand sanitizer and the remote at staff as well, and threatened to throw a pitcher of water at staff.</p> <p>-9/28/11 (6 AM to 2 PM) client A threw milk in a peer's face.</p> <p>-9/25/11 client A threatened to throw items at staff.</p> <p>-9/21/11 client A was at the back of the house throwing items at the other clients "agitating them." The progress note indicated client A had thrown dish soap all over the kitchen, by the front door and</p>			

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	<p>the walls.</p> <p>-9/7/11 (6 AM to 2 PM) client A refused his medications, cursed and yelled at other clients and staff, and threw things at staff and the clients.</p> <p>-9/7/11 (10:30 AM) staff was in kitchen putting groceries away when client A came into the kitchen and started throwing a water bottle at staff.</p> <p>-9/3/11 client A was throwing items and cussing at staff. Client caused other clients to "become agitated."</p> <p>Client A's 7/15/11 Behavior Support Plan (BSP) indicated client A demonstrated physical aggression which was defined as "In any way harming, or attempting to harm another individual. This includes but is not limited to; pushing, and punching." Client A's 7/15/11 BSP indicated facility staff were to "Gently block all aggressive moves to protect [client A] and others around him...b. verbally redirect [client A] to participate in a chosen relaxation technique. b. (sic) Non-physical Escort [client A] by prompting him to move away from the source of his frustration/anger by getting him involved in an activity. c. Physically Redirect. Move [client A] away from the person he is targeting to insure (sic)</p>			

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	<p>everyone's safety...." Client A's 7/15/11 BSP did not specifically indicate what facility staff were to do to prevent client A from throwing objects and/or fluids onto others.</p> <p>Interview with client G on 10/4/11 at 5:25 PM indicated client A had thrown water on client F.</p> <p>Confidential staff interview A indicated client A would throw items at others. Confidential staff interview A stated "He (client A) is an antagonist." Confidential interview A indicated client A would throw water on the other clients and staff.</p> <p>Confidential staff interview B indicated client A would throw things, pour and throw pitchers of water at others. Confidential interview B stated client A would "target" other clients who would not respond or retaliate. Confidential staff interview B indicated the clients were ok with client A until he started to throw things. Confidential interview B indicated clients C and F were getting tired of client A's throwing items them and others.</p> <p>Confidential staff interview C indicated client A would throw items at others and then run.</p>				

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W0331	<p>Confidential staff interview E indicated client A would throw items and water at/on others.</p> <p>Confidential staff interview F indicated client A would throw objects at staff, clients and poured milk on clients as they sat on the couch.</p> <p>Interview with administrative staff #3 on 10/5/11 at 11:20 AM indicated client A's 7/15/11 BSP did not specifically address/tell facility staff how they were to handle/prevent client A from throwing objects at others and/or throwing/pouring fluids on others.</p> <p>This federal tag relates to complaint #IN00097770.</p> <p>9-3-4(a)</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 1 of 4 sampled clients (A), the facility's nursing services failed to ensure facility staff contacted the nurse in regard to a client's injury/rash for a medical evaluation/assessment.</p> <p>Findings include:</p> <p>During the 10/4/11 observation period</p>	W0331	<p>CORRECTION: <i>The facility must provide each client with nursing services in accordance with their needs.</i> Specifically for Client A, the facility nurse has been informed of the injury, which has since healed. Professional staff was placed on administrative leave while the origin of the injury and subsequent failure to report it was investigated. PREVENTION: Professional staff will receive</p>	11/11/2011	

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	<p>between 5:40 AM and 8:15 AM, at the group home, client A had a large (4 to 5 inch) fading yellow bruise to the back of his right upper arm which was circular in shape. Client A also had a thumb print size circular black bruise on his upper right inner arm.</p> <p>Client A's record was reviewed on 10/5/11 at 10:37 AM. Client A's 9/30/11 Progress Notes indicated "5:30 PM [Client A] showed (R) (right) arm to his mother said that a staff had did it. Bruised on his (R) arm-to her it didn't look like a rash to her. She (client's mother) stated it look like a bruise that was going away. She took picture of it. [Staff #1] showed her the picture that was taken earlier with red bumps on it. Bumps had went, but still red (sic)."</p> <p>Client A's 8/11 Nursing Monthly Summary (current one in the record) did not indicate the facility's nurse evaluated client A's injury and/or rash.</p> <p>Interview with nurse staff #1 on 10/5/11 at 3:25 PM, by phone, indicated she was not aware of client A's injury to his right arm. Nurse staff #1 indicated she should have been contacted to evaluate/assess client A's injury/rash.</p> <p>Interview with staff #1 on 10/5/11 at 4:09</p>		<p>appropriate performance action for failure to report an injury to the nurse and administrative staff. All facility staff will be retrained regarding nurse notification procedures. Additionally, on an ongoing basis, members of the Operations Team will periodically review facility records including but not limited to Weekly Body Check forms and compare them to incident reports to assure all injuries are reported in a timely manner Responsible Parties: QDDPD, Support Associates, Health Services Team, Operations Team</p>		

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	<p>PM, by phone, indicated she was aware of the area on client A's arm. Staff #1 indicated she thought the area on client A's right arm was a rash as it had red bumps. Staff #1 indicated the client's mother was concerned that it looked like a bruise. Staff #1 indicated the facility's nurse was not aware of client A's injury/rash.</p> <p>This federal tag is related to complaint #IN00097770.</p> <p>9-3-6(a)</p>				