

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 12/20/2011
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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 a post certification revisit (PCR) survey to complaint #IN00097770 completed on 10/12/11.</p> <p>This visit was in conjunction with the investigation of complaint #IN00099872.</p> <p>Complaint #IN00097770-Not Corrected.</p> <p>Unrelated deficiency cited.</p> <p>Dates of Survey: 12/15, 12/16 and 12/20/11</p> <p>Facility Number: 001008 Provider Number: 15G494 Aim 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 12/22/11 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</i>	01/19/2012

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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W0407	<p>general policy and operating direction over the facility to ensure a client was appropriately placed to meet the client's behavioral and psychiatric needs.</p> <p>Findings include:</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure client A was placed in an environment which was appropriate and more structured for the client's behavioral/psychiatric needs due to the client's potential harm to self and/or others. Please see W104.</p> <p>This federal tag relates to complaint #IN00097770.</p> <p>This deficiency was cited on 10/12/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(a)</p> <p>The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (A), the facility failed to ensure the client</p>	W0407	<p><i>policy, budget and operating direction over the facility.</i></p> <p>Specifically, the interdisciplinary team has informed the Bureau of Developmental Disability Services of the need to locate a residential setting that meets Client A's developmental and behavioral needs with an appropriately matched peer group. The Operations Team has also informed BDDS that no such placement exists within Client A's current agency. PREVENTION: The agency has revised referral assessment materials to include evaluation of how prospective housemates relate socially and developmentally to the individuals already living in SGL facilities. The Operations Team will continue to monitor and oversee the referral process to assure that clients are placed in a socially and developmentally appropriate environment. RESPONSIBLE PARTIES: QDDP, Support Associates, Operations Team</p> <p>CORRECTION: <i>The facility must not house clients of grossly different ages, developmental levels and social needs in close</i></p>	01/19/2012	

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	<p>was placed in an environment which was appropriate and more structured for the client's behavioral/psychiatric needs due to the client's potential harm to self and/or others.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 12/15/11 at 11:57 AM. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive):</p> <p>-12/14/11 "When [client A] returned from the ER (emergency room)...., he (client A) told staff he was still depressed and agitated. He paced through the chouse (sic) and yelled at intervals. He began voicing suicidal ideation and making threats. He threw a container of hand soap at [client B], which hit [client B] above his left eye and resulted in a reddened area. [Client A] then used the house telephone to call the police and reported that he wanted to kill himself. Police arrived and transported [client A] to the [name of hospital] where he was evaluated and released without recommendations at 3:00 AM on 12/15/11...."</p> <p>-12/14/11 at 3:05 PM, "[Client A]</p>		<p><i>physical or social proximity unless the housing is planned to promote the development of all those housed together.</i> Specifically, the interdisciplinary team has informed the Bureau of Developmental Disability Services of the need to locate a residential setting that meets Client A's developmental and behavioral needs with an appropriately matched peer group. The Operations Team has also informed BDDS that no such placement exists within Client A's current agency. PREVENTION: The agency has revised referral assessment materials to include evaluation of how prospective housemates relate socially and developmentally to the individuals already living in SGL facilities. The Operations Team will continue to monitor and oversee the referral process to assure that clients are placed in a socially and developmentally appropriate environment. RESPONSIBLE PARTIES: QDDP, Support Associates, Operations Team</p>		

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	<p>complained of a headache and was assessed by the SGL (Supported Group Living) nurse. He was not satisfied with nurse's assessment and said that there was something wrong with his head and since no one wanted to help him he was going to walk to the emergency room. He exited the house through its unlocked door and began walking. Staff followed in the can (sic) and encouraged him to get into the vehicle but he refused and continued walking. Staff remained with [client A] as he continued his walk to [name of hospital] which is located 1.7 miles from his SGL residence...."</p> <p>-12/14/11 at 6:45 AM, "[Client H] was resisting staff prompts to participate in his morning routine. [Client A] went to [client H's] bedroom doorway and began yelling at and using profanity toward [client H] because [client A] perceived [client H] was being disrespectful toward staff. [Client H] entered [client A's] personal space and told him not to enter his room. [Client A] pushed [client H] and [client H] responded by hitting [client A] in the left side of his face...."</p> <p>-12/7/11 "Due to [client A's] ongoing struggles with elopement, physical aggression and property destruction, [name of behavioral services] and [client A's] attending psychiatrist consensually</p>				

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	<p>agreed with SGL and administrative staff that [client A] would benefit from in-patient psychiatric treatment. Intake procedures at [name of hospital] were initiated on the night of 12/6/11 and [client A] was admitted for in-patient treatment after guardianship papers were received on the morning of 12/7/11...."</p> <p>-12/5/11 3:50 PM, "[Client A] walked out of his home's unlocked back fire door and staff followed him immediately. [Client A] ran and was out of staff's line of site (sic) and staff called the police per the elopement protocols in [client A's] Behavior Support Plan (BSP). Police located [client A] walking East on [name of street] and returned him to the house at 5:30 PM. He remained agitated and voiced suicidal ideation throughout the evening and he called the Police at 8:50 PM and told them he wanted to kill himself. Police arrived and transported [client A] to the [name of hospital] for evaluation. [Name of hospital] released [client A] to SGL staff at 3:30 AM with no recommendations...The Program Coordinator...will consult with [client A's] behavioral specialist and attempt to develop supports in which [client A] is willing to participate."</p> <p>-12/4/11 "[Client A] was sitting on the couch next to a housemate (client D) and</p>				

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	<p>began yelling and using profanity. When his housemate got up to move away, [client A] hit him in the back. He went to his room and came out with a key and told staff he was going to repair the shed. He unlocked the shed and got out his bicycle from which he is restricted from riding. Due to his history of elopement on his bicycle, staff called the police before he could leave the residence. Police arrived and he told them that he wanted to kill himself and needed to be hospitalized. He told them that he did not want to be taken to [name of hospitals] because they were not willing to help him. Police agreed to take him to [name of hospital] where he was evaluated and released at 8:15 PM with no recommendations. When he returned home he remained agitated and voicing suicidal ideation. He attempted multiple times to leave the house and with supervisory approval, staff transported [client A] to [name of hospital], where he was again evaluated and released with no recommendations. The team will consult with [client A's] behavioral specialist and attempt to develop supports in which [client A] is willing to participate."</p> <p>-12/3/11 "[Client A] became agitated and began yelling and throwing objects. He walked out of the house, accompanied by staff three times. The third time he exited the building he said he was going to</p>				

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	<p>[name of hospital] because he wanted to kill himself and needed help. Staff offered to drive [client A] to the Emergency Room but he declined and said he wanted to walk. Staff walked with [client A] to the [name of hospital] Emergency Department which is seventh tenths of a mile from his SGL residence. ER personnel indicated that [client A] would be admitted for observation but after evaluation determined that [client A] did not meet the criteria for psychiatric admission. [Client A] was released to SGL staff and returned home...."</p> <p>-11/28/11 "Staff [staff #2] reported that he (staff #2) discovered the house phone was broken. When he asked staff [staff #3] what happened, [staff #3] stated [client A] (individual we support) became agitated, picked up the phone and threw it. This resulted in breaking the phone. No one was injured during this incident...."</p> <p>-11/13/11 "[Staff #1] walked into [client E's] (individual we support) room and saw [client E] and peer [client A] (individual we support) fighting. [Client A] had [client E] pinned to the floor. [Staff #1] asked [client A] to get off [client E] and [client A] did so...." The 11/13/11 reportable indicated staff #1 had to utilize Your Safe I'm Safe (behavioral management techniques) to keep client E</p>				

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	<p>from grabbing client A. The 11/13/11 reportable incident report indicated "...IDT (interdisciplinary team) to meet for each individual to discuss recent increase in aggressive behaviors and determine strategies to reduce incident reoccurrence."</p> <p>-11/12/11 at 12:40 PM, client A became upset after being attacked by another peer in the group home. The reportable incident report indicated "...[Client A] came out of his room appearing irritated, said he couldn't take it and walked out of the house. Staff followed and attempted to verbally redirect [client A] to return to the home. [Client A] declined and walked down the road. Staff called PC (Program Coordinator) to report the incident. [PC #1] initiated a search for [client A] in the local neighborhood as well as the library and stores [client A] may walk to. [Client A] was not located. The police were contacted. [Client A] returned home at 3:18pm. When asked, [client A] said he left because his peer attacked him and that he went to the library...."</p> <p>-11/11/11 at 6:15 PM, "[Staff #4] saw [client A] (individual we support) in his room at 615 pm (sic). Other staff on duty were assisting [client A's] housemate with getting ready for dinner. Staff went to [client A's] room just before 630 pm (sic)</p>				

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	<p>to ask him to come to dinner. [Client A] did not respond when staff asked him to come to dinner. Staff entered [client A's] room and he was not there. Staff called PC [PC #1] and began looking for [client A] in the neighborhood. [Client A] was not located. The police were contacted and initiated a search for [client A]. [Client A] returned home at 8:25 pm. [Client A] stated that he had left home to find an auto store so he could get some spare keys...[Client A] has a behavior support plan which addresses elopement as a targeted behavior...[Client A] met with his behavioral consultant (BC), (BC #1), last week. Staff was implementing 15 minute checks, which [client A] evaded, during this incident. The residential and behavioral team will be contacted to determine additional strategies to be implemented."</p> <p>-9/28/11 client A was upset over restrictions (not able to ride bike) which was 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 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</p>				

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	<p>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 transported him to [name of hospital] for an emergency psychiatric evaluation. [Client A] was assessed and released with no recommendations...."</p>				

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	-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 evaluation. [Name of hospital] transferred [client A] to [name of psychiatric hospital], where he was released to SGL staff at 2:00 PM....."				

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	<p>During the 12/15/11 observation period between 5:45 AM and 7:45 AM, at the group home, there was a fist size hole in the plaster of the wall in the hallway going to the clients' bedrooms. During the 12/15/11 observation period, client A asked PC #1 about going to the library. PC #1 told the client he would need to wait and talk about that later as there were other things which needed to be done. Client A continued to ask PC #1 about going to the library. Interview with client A on 12/15/11 at 7:25 AM stated, "I'm irritated." Also during the 12/15/11 observation period, client A did not attend a workshop and/or day program, but rode along with his peers to be dropped off.</p> <p>Interview with client A on 12/15/11 at 6:28 AM indicated client A placed the hole in the wall on 12/14/11 as he was upset. Client A indicated he had been to a local hospital 2 times on 12/14/11. Client A indicated he threw a bottle of alcohol gel and hit client B in the head with it. Client A stated "I did not meant to hit [client B]. I was trying to hit [client H]." Client A indicated he would get upset and get angry. Client A indicated he got his bike out of the shed a few weeks ago. Client A indicated he was going to leave the group home, but staff called the police and they stopped him. Client A indicated he was seeing a counselor for his anger</p>						

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	<p>management. Client A indicated he did not like living at the group home and wanted to live elsewhere.</p> <p>Client A's record was reviewed on 12/15/11 at 12:49 PM. Client A's Progress Notes indicated the following (not all inclusive):</p> <p>-10/13/11 client A wanted to use the bathroom while another client was in the bathroom. The note indicated "...[client A] pulled him (client F) by his arms out the bathroom door. [Client F] ran into the living room cussing and yelling while [client A] was following behind him explaining to staff that he (client A) was trying to be nice...."</p> <p>-11/1/11 (10 PM to 8 AM) second note indicated client A was outside when the staff arrived to the group home throwing items at staff and a housemate. The note indicated the housemate called 911 and client A "...told the police he want to kill himself (sic), they took [client A] to the hospital,...."</p> <p>-11/1/11 (10 PM to 8 AM) second note indicated client A threatened to tell administrative staff on the group home staff if the group home staff did not do what he wanted. The note indicated "...if he (client A) don't get his way he tell</p>				

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	<p>[administrative staff #2] and they will lose they (sic) job everyday every staff hears this and it gets old..." The 11/1/11 note indicated client A tried to break the mirror in the front room, threw items at staff and "bragged about it" to someone he was talking to on the phone.</p> <p>-11/1/11 (2 PM to 10 PM) client A was outside talking to the neighbors when "...after awhile staff noticed he was nowhere to be found. He had ran (sic) off. Staff spotted him going toward [name of hospital] and asked him to come back home with her but he refused and kept walking on [name of street]. Staff continued to follow him until he was out of sight. He came back home with the PC...." The note indicated client A left the group home a second time on 11/1/11 while staff was assisting another client.</p> <p>-11/2/11 (6 AM to 2 PM) client A "...started yelling and cussing at another consumer (client H) and telling him what to do. The consumer got very upset and ran after [client A]...." The note indicated once staff got both clients calm, client A started cursing at client H again.</p> <p>-11/2/11 (2 PM to 10 PM) client A eloped from the group home with staff following the client. The note indicated staff followed the client until client A was out</p>				

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	<p>of sight and the police was called. The note indicated the police returned the client to the group home and the police returned to check on the client later that evening.</p> <p>-11/3/11 (6 AM to 2 PM) client A became upset as another client had money to go out to eat. The note indicated client A "...started throwing stuff. [Client A] threw sanitizer and (sic) [client B] in his arm. [Client A] call (sic) the police department and tell (sic) them he wants them to come and take him to an institution. Police call (sic) back and wanted to speak to staff...The operator said [client A] keeps calling them. Staff explain (sic) to operator what was going on. Operator said they will not take no emergency call [client A] (sic)."</p> <p>-11/3/11 "[Client A] eloped at 3:30pm. Staff follow (sic) him and he refused to get on the van, staff (sic) said he was going to the library, so staff went to pick up [name of workshop] consumers, staff went back later to the library to see if he was still there and he was, and he refuse (sic) to come back with staff. Police brought him back at 7:15pm. [Client A] went to get his dinner and said he didn't want that s..t and broke the plate on the floor and kept cussing and laughing."</p>				

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	<p>-11/4/11 client A threatened to get all the staff suspended.</p> <p>-11/11/11 client A eloped from the group home and was found by the police.</p> <p>-11/14/11 "[Client A] started igatating (sic) another consumer yelling and cussing...."</p> <p>-11/28/11 client became agitated and started throwing things at others and cussing at others.</p> <p>-11/30/11 client A was arguing with another client.</p> <p>-12/3/11 eloped from group home but returned with staff in the van.</p> <p>-12/3/11 (second note) client A eloped from the group home again. Client refused to get on the van with staff and stayed in front of a local business for an hour before returning with staff. The note indicated once client A returned home, the client threw items at the other clients, broke the blinds and was later taken to a local hospital for evaluation.</p> <p>-12/4/11 (4 PM to 10 PM) "...[Client A] came in living room at dinner time and started cussing the consumers and calling them b...[client D] got up to move and</p>				

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	<p>[client A] hit him in the back...[Client A] told staff he has key to shed." The note indicated client A "...walk (sic) out of the group home to [name of hospital], and staff following him to the hospital. [Client A] stay (sic) in the hospital all night."</p> <p>-12/5/11 (8 AM to 4 PM) "...[Client A] was talking on the phone in living are (sic). Staff overheard him telling someone he stole the Bolton home shed key, and he was going to take his bike. He was telling, bragging how he called staff curse words. He said he was going to eat staff (sic) food to make staff mad, and he threw stuff at staff to see what staff would do."</p> <p>-12/5/11 (2 PM to 10 PM) client A became agitated when his girlfriend told him she had a job. The note indicated client A began to curse and throw staff's keys hitting another client in the back. The 12/5/11 note indicated client A threw water and his food at the dinner all over another client. The note indicated he called a behavioral service to see if he could get help. The 12/5/11 note indicated "...He keeps talking about he's going to kill him-self. He said he is going to call 9-11(sic) so they can take him to the hospital, [client A] also eloped this evening and he was returned by the</p>				

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	<p>police."</p> <p>-12/6/11 (2 PM to 10 PM) "...He was taken to hospital by staff to get some help."</p> <p>-12/14/11 (6 AM to 2 PM) Client A started yelling and cursing at a client in the client's room. The note indicated both clients were yelling at and punching each other.</p> <p>-12/14/11 client A complained he was dizzy and the nurse came to assess the client. The note indicated client A was speaking with his mother on the phone and the client became upset and threw the phone, took the phone from another client and unplugged the phone and threw a sanitizer bottle and hit client B in the head. The note indicated client A also beat on the back window with his hand, knocked a hole in the wall and called 911 as he threatening to hurt himself. The 12/14/11 note indicated the police came and took client A to the hospital.</p> <p>Client A's 12/10/11 hospital discharge orders indicated client A's Abilify (antipsychotic/behavior) was increased to 10 milligrams daily and the client's Buspar (behavior) was decreased while hospitalized.</p>				

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	<p>Client A's 12/15/11 Record Of Visit note from the therapist indicated client A's diagnoses included, but were not limited to, Obsessive Compulsive Disorder and Personality Disorder. The 12/15/11 note indicated the following: "1) 24 hours no outings for property destruction, physical aggression, self harm/threats self/others, AWOL/Elopement 2) Call police if unsafe."</p> <p>Client A's 1/6/11 Person Centered Planning Profile indicated "...[Client A] continues to require ICF/MR (Intermediate Care Facility for the Mentally Retarded) 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 and nutritional needs without continuous supervision, training and staff support...."</p> <p>Client A's 11/1/11 Individual Support Plan (ISP) indicated client A's diagnoses included, but were not limited to, Attention Deficit Disorder, Anxiety Disorder, Depressive Disorder No Other Symptoms and Autism Spectrum Disorder. Client A's 11/1/11 ISP</p>				

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	<p>indicated client A lived at 2 previous group homes within the agency (Voca/Res-care) since 6/4/09. Client A's 11/1/11 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 8/22/11 IDT (interdisciplinary team) note indicated client A moved to the Bolton Group home on 8/20/11.</p> <p>Client A's 11/10/11 Behavior Support Plan (BSP) indicated client A's behavior was harmful to himself, "...2) infringes on the rights of others, 3) symptoms of a psychiatric diagnosis;...." Client A's 11/10/11 BSP indicated client A demonstrated property destruction, verbal disruption, elopement, suicidal ideation, aggression and medication refusals. The 11/10/11 BSP indicated client A received Zoloft, Buspar and Abilify for the client's behavior/psychiatric diagnoses.</p> <p>Interview with staff #5 on 12/15/11 at 7:47 AM indicated client had been to the hospital 2 times on 12/14/11 and had been hospitalized for a week due to his behaviors in the past 3 weeks. Staff #5 stated client A "wants to kill self." Staff</p>				

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	<p>#5 indicated client A had thrown a bottle of alcohol gel and hit client B in the head on 12/14/11. Staff #5 stated client A's behaviors were "affecting the other consumers." Staff #5 stated client A "controls other consumers and causes behaviors."</p> <p>Interview with staff #6 on 12/15/11 at 8:02 AM stated client A was "very rude to guys and intimidating to get what he wants." Staff #6 stated client A's behavior was affecting the other clients as client G was refusing to get up out of bed as client A was "very intimidating." Staff #6 indicated client A was on 15 minute checks but would still elope from the group home. Staff #6 indicated client A was telling staff and others he wants to kill himself. Staff #6 indicated client A's threatening to harm himself had increased.</p> <p>Interview with administrative staff #2 on 12/15/11 at 10:20 AM indicated he had tried to get client A moved to an Extensive Need Support (ENS) group home to no avail. Administrative staff #2 indicated client A had not been successful at any of his group home placement due to his behaviors. Administrative staff #2 indicated client A needed more structure than Bolton group home could offer. Administrative staff #2 stated "Doctor</p>				

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	<p>says it is behavioral, no medications will help him."</p> <p>Interview with administrative staff #1 on 12/15/11 at 10:45 AM stated "We have tried everything with [client A]. He does not want to be here. He just got back from being inpatient. He is going to be a problem no matter where he goes." Administrative staff #1 indicated the staff at the group home had tried to make client A feel wanted at the group home. Administrative staff #1 indicated client A had been in 3 different group homes placements in the agency.</p> <p>Interview with client A's guardian on 12/15/11 at 2:25 PM, by phone, indicated client A was not doing good at the current group home. Client A's guardian indicated client A had been moved/transferred to 3 different group homes within the agency. Client A's guardian indicated client A became upset on 12/14/11 and was sent out to the hospital again. Client A's guardian indicated client A had returned from an inpatient stay on a behavioral unit in the past week. Client A's guardian indicated she was present by phone at client A's last psychiatric appointment. Client A's guardian stated the psychiatrist indicated "Medications will not change behavior." Client A's guardian indicated the doctor</p>				

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	<p>felt client A's issues were behavioral.</p> <p>Interview with PC #1 on 12/16/11 at 10:20 AM indicated client A did not attend a workshop and/or day program due to the client's behavior. PC #1 indicated she had tried to get the client back into the workshop but client A called the workshop and cursed out the workshop staff. PC #1 indicated client A was admitted to the group home from another agency group home in 8/11. PC #1 indicated they had been having behavioral issues with client A since he moved to the group home. PC #1 indicated there had been an increase of threats to hurt self and elopement in the past month. PC #1 indicated client A was seeing a therapist and being followed by a behavioral service with a counselor 2 times a week. PC #1 indicated client A was discharged from an inpatient stay on December 12/16/11 after the client was admitted on 12/13/11. PC #1 stated client A was "very intelligent but needs to learn to control impulsive behavior." PC #1 indicated client A's behavior was affecting the other clients as they were becoming more vocal and/or complaining about client A to others. PC #1 stated client A's psychiatrist did not feel medications would help/control client A's actions as they were "behavioral." PC #1 indicated client A's therapist feels more</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	consequences needed to be implemented than what the agency/group home can do. 9-3-7(a)				