

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G201	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/04/2013
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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN	STREET ADDRESS, CITY, STATE, ZIP CODE 305 NE THIRD ST LOGOOTE, IN 47553
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W000000	<p>This visit was for a full recertification and state licensure survey. This visit resulted in an Immediate Jeopardy.</p> <p>Dates of Survey: August 26, 27, 28, 29, 30, September 3 and 4, 2013.</p> <p>Surveyor: Dotty Walton, QIDP.</p> <p>Facility Number: 000731 AIM Number: 100243220 Provider Number: 15G201</p> <p>The following deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/12/13 by Ruth Shackelford, QIDP.</p>	W000000		

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

TITLE

(X6) DATE

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

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W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3, and #4), and 3 additional clients (#5, #6 and #7), the facility failed to meet the Condition of Participation: Governing Body. The facility's Governing Body failed to exercise general operating direction over the facility by failing to ensure the rights of all clients by neglecting to implement policies and procedures which prohibited client neglect and abuse.</p> <p>Findings include:</p> <p>Please refer to W104 for 4 of 4 sampled clients (#1, #2, #3, and #4), and 3 additional clients (#5, #6 and #7), for the Governing Body's failure to exercise general operating direction over the facility by failing to implement policies and procedures which prohibited client neglect and abuse.</p> <p>Please refer to W122 Condition of Participation: Client Protections for 4 of 4 sampled clients (#1, #2, #3, and #4), and 3 additional clients (#5, #6 and #7), for the governing body's neglecting to</p>	W000102	<p>Corrective action: The facility will train/inservice all staff at this location and Day Program designee on policies and procedures concerning client neglect and abuse, the definition of all types of abuse including verbal abuse, emotional abuse, intimidation, and psychological abuse. (ATTACHMENT A&B)</p> <p>The facility will train/inservice all staff at this location and Day Program designee on policies and procedures concerning client rights and protections. (ATTACHMENT B&C)</p> <p>The facility will train/inservice YSIS (You're Safe, I'm Safe) Physical Safety techniques, and behavior management crisis resolution to all staff at this location during orientation, and annually for recertification. (ATTACHMENT D)</p> <p>The facility will relocate client #1, housing him away from previous housemates, eliminating his ability to endanger either the physical, psychological, or emotional health. (ATTACHMENT E&R)</p> <p>This facility will make available to all residents of this group home additional counseling/ therapy as needed or requested to ensure the continued positive mental and psychological health. (ATTACHMENT E&S)</p> <p>The</p>	09/23/2013			

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	<p>implement policies and procedures which prohibited verbal, emotional and psychological abuse of clients #2, #3, #4, #5, #6 and #7. The governing body also failed to thoroughly investigate and implement remedies regarding client #1's repeated elopements and the impact his behavioral outbursts had upon his fellow housemates (verbal, emotional and psychological abuse of clients). This failure resulted in Immediate Jeopardy.</p> <p>Please refer to 266 Condition of Participation: Client Behavior & Facility Practices for 4 of 4 sampled clients (#1, #2, #3, and #4), and 3 additional clients (#5, #6 and #7), for the governing body's failure to implement plans to address client #1's verbal, emotional and psychological abuse of clients #2, #3, #4, #5, #6 and #7. The governing body also failed to protect client #1 by failing to effectively deal with his elopements into high traffic areas (state highways).</p> <p>9-3-1(a)</p>		<p>facility will train/inserve Client rights and grievance policies to all consumers upon admission and annually. (ATTACHMENT F)The facility will obtain a Behavior Consultant for client #1. (ATTACHMENT G)A new functional assessment will be completed for client #1. (ATTACHMENT H)A new Behavior Plan for client #1 will be written, trained/Implemented for all necessary staff. (ATTACHMENT I)Client #1 will be housed elsewhere while alternate placement is located. He will not return to this group home. (ATTACHMENT E)Client #1 will be staffed 2:1 @ all times. (ATTACHMENT E)The facility will investigate all reportable incidents; any substantiated incidents will be addressed through programming goal, behavior modification goals, and necessary steps to protect the rights of all individuals. (ATTACHMENT J)Administrative Team will make appropriate recommendations for any corrective action needed. (ATTACHMENT J)Consumer's IDT will convene to discuss the outcome/recommendations from Appropriate Parties. (ATTACHMENT K)All corrective measures recommended by Appropriate Parties and reviewed and approved by IDT will be written in ISP/BSP trained and implemented. (ATTACHMENT K) How we will identify others:</p>		

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			<p>The Clinical Supervisor will review all behavior and incident documentation weekly to identify like issues. (ATTACHMENT L)The Clinical Supervisor will review all plans to ensure all client trainings are completed. (ATTACHMENT M)Clinical Supervisor will do a functional assessment at admission and annually for each consumer to identify specific individual needs in behavior management, and ADL's/Goals. Appropriate Parties will investigate all alleged incidents per policy and procedure. (ATTACHMENT J)Appropriate Parties will make appropriate recommendations for any corrective action needed. (ATTACHMENT J)Consumer's IDT will convene to discuss the outcome/recommendations from Appropriate Parties. (ATTACHMENT K&N) Measures to be put in place:The Clinical Supervisor will ensure all staff have been trained on client's rights and protections, and have been trained on abuse and neglect. (ATTACHMENT A,B,& C) The Clinical Supervisor will review all plans to ensure all client trainings are completed. (ATTACHMENT M)Clinical Supervisor will implement/train plan addendums when an identified issue is determined. (ATTACHMENT O)The Clinical Supervisor will conduct monthly meetings and review for all staff: behavior documentation,</p>	

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			<p>incidents reportable and internal, abuse and neglect definition, ResCare policy on abuse and neglect, reporting, Client rights and protections, and review of ISP, BSP, and HRP. (ATTACHMENT P)All staff will attend an YSIS recertification training annually. (ATTACHMENT D)Clinical Supervisor will ensure all incidents are documented and reported to Appropriate Parties. (ATTACHMENT J)Appropriate Parties will follow policy and procedures for all reported incidents. (ATTACHMENT J)Consumer's will attend monthly client council meetings to discuss agency activities, grievance procedures, medical options, responsibilities, home and community safety, community activities, living options, rights, self-advocacy, and nutrition.. (ATTACHMENT Q) Monitoring of Corrective Action:Operations Manager and Program Manager will conduct Best in Class, and periodic reviews to ensure all policies and procedures are being followed.Operations Manager and Appropriate Parties will review all ISP's, BSP'S, and all addendums before training and implementation.</p>		

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W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3, and #4), and 3 additional clients (#5, #6 and #7), for the Governing Body's failure to exercise general operating direction over the facility by failing to implement policies and procedures which prohibited client neglect and abuse.</p> <p>Findings include:</p> <p>Please refer to W149 for the governing body's failure for 4 of 4 sampled clients (#1, #2, #3 and #4), plus 3 additional clients (#5, #6, and #7), to implement written policies and procedures which prohibited mistreatment (intimidation), neglect or psychological abuse of clients.</p> <p>Please refer to W285 for the facility's failure for 1 of 4 sampled clients (#1), to ensure behavior management techniques (physical escort/restraint) were employed in such a way so as to ensure the safety (prevent injury) of the client.</p> <p>9-3-1(a)</p>	W000104	<p>Corrective action: The facility will train/inservice all staff at this location and Day Program designee on policies and procedures concerning client neglect and abuse, the definition of all types of abuse including verbal abuse, emotional abuse, intimidation, and psychological abuse. (ATTACHMENT A&B)</p> <p>The facility will train/inservice all staff at this location and Day Program designee on policies and procedures concerning client rights and protections. (ATTACHMENT B&C)</p> <p>The facility will train/inservice YSIS (You're Safe, I'm Safe) Physical Safety techniques, and behavior management crisis resolution to all staff at this location during orientation, and annually for recertification. (ATTACHMENT D)</p> <p>The facility will relocate client #1, housing him away from previous housemates, eliminating his ability to endanger either the physical, psychological, or emotional health. (ATTACHMENT E&R)</p> <p>This facility will make available to all residents of this group home additional counseling/ therapy as needed or requested to ensure the continued positive mental and psychological health. (ATTACHMENT E&S)</p> <p>The</p>	09/23/2013	

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			<p>facility will train/inservice Client rights and grievance policies to all consumers upon admission and annually. (ATTACHMENT F)The facility will obtain a Behavior Consultant for client #1. (ATTACHMENT G)A new functional assessment will be completed for client #1. (ATTACHMENT H)A new Behavior Plan for client #1 will be written, trained/Implemented for all necessary staff. (ATTACHMENT I)Client #1 will be housed elsewhere while alternate placement is located. He will not return to this group home. (ATTACHMENT E)Client #1 will be staffed 2:1 @ all times. (ATTACHMENT E)The facility will investigate all reportable incidents; any substantiated incidents will be addressed through programming goal, behavior modification goals, and necessary steps to protect the rights of all individuals. (ATTACHMENT J)Administrative Team will make appropriate recommendations for any corrective action needed. (ATTACHMENT J)Consumer's IDT will convene to discuss the outcome/recommendations from Appropriate Parties. (ATTACHMENT K)All corrective measures recommended by Appropriate Parties and reviewed and approved by IDT will be written in ISP/BSP trained and implemented. (ATTACHMENT K) How we will identify others:</p>		

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			The Clinical Supervisor will review all behavior and incident documentation weekly to identify like issues. (ATTACHMENT L)The Clinical Supervisor will review all plans to ensure all client trainings are completed. (ATTACHMENT M)Clinical Supervisor will do a functional assessment at admission and annually for each consumer to identify specific individual needs in behavior management, and ADL's/Goals. Appropriate Parties will investigate all alleged incidents per policy and procedure. (ATTACHMENT J)Appropriate Parties will make appropriate recommendations for any corrective action needed. (ATTACHMENT J)Consumer's IDT will convene to discuss the outcome/recommendations from Appropriate Parties. (ATTACHMENT K&N) Measures to be put in place:The Clinical Supervisor will ensure all staff have been trained on client's rights and protections, and have been trained on abuse and neglect. (ATTACHMENT A,B,& C) The Clinical Supervisor will review all plans to ensure all client trainings are completed. (ATTACHMENT M)Clinical Supervisor will implement/train plan addendums when an identified issue is determined. (ATTACHMENT O)The Clinical Supervisor will conduct monthly meetings and review for all staff: behavior documentation,	

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			<p>incidents reportable and internal, abuse and neglect definition, ResCare policy on abuse and neglect, reporting, Client rights and protections, and review of ISP, BSP, and HRP. (ATTACHMENT P)All staff will attend an YSIS recertification training annually. (ATTACHMENT D)Clinical Supervisor will ensure all incidents are documented and reported to Appropriate Parties. (ATTACHMENT J)Appropriate Parties will follow policy and procedures for all reported incidents. (ATTACHMENT J)Consumer's will attend monthly client council meetings to discuss agency activities, grievance procedures, medical options, responsibilities, home and community safety, community activities, living options, rights, self-advocacy, and nutrition.. (ATTACHMENT Q) Monitoring of Corrective Action:Operations Manager and Program Manager will conduct Best in Class, and periodic reviews to ensure all policies and procedures are being followed.Operations Manager and Appropriate Parties will review all ISP's, BSP'S, and all addendums before training and implementation.</p>	

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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3, and #4), and 3 additional clients (#5, #6, #7), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to ensure the rights of all clients to be free of neglect, verbal, emotional and physical abuse by failing to address client #1's elopements, physical and verbal aggression/intimidation.</p> <p>This noncompliance resulted in an Immediate Jeopardy. An Immediate Jeopardy was identified on 8/28/2013 at 12:00 PM that had existed at the facility since 8/08/2013 at 9:17 AM. The Agency's Operations Manager/OM staff #1 was notified of the Immediate Jeopardy on 8/28/2013 at 3:22 PM.</p> <p>Electronic correspondence from Executive Director #1 on 9/3/13 at 7:54 PM indicated a BC (Behavioral Consultant) had been "secured" to "assess and evaluate" client #1 in regards to his identified behavioral needs the afternoon of 9/4/13.</p> <p>A revised plan of action to remove the Immediate Jeopardy was submitted via</p>	W000122	<p>Corrective action: The facility will train/in-service all staff at this location and Day Program designee on policies and procedures concerning client neglect and abuse, the definition of all types of abuse including verbal abuse, emotional abuse, intimidation, and psychological abuse. (ATTACHMENT A&B) The facility will train/in-service all staff at this location and Day Program designee on policies and procedures concerning client rights and protections. (ATTACHMENT B&C)The facility will train/in-service YSIS (You're Safe, I'm Safe) Physical Safety techniques, and behavior management crisis resolution to all staff at this location during orientation, and annually for recertification. (ATTACHMENT D)The facility will relocate client #1, housing him away from previous housemates, eliminating his ability to endanger either the physical, psychological, or emotional health. (ATTACHMENT E&R)This facility will make available to all residents of this group home additional counseling/ therapy as needed or requested to ensure the continued positive mental and psychological health. (ATTACHMENT E&S)The facility will train/in-service Client</p>	09/23/2013			

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	<p>electronic mail by OM #1 on 9/3/13 at 8:57 PM:</p> <p>"UPDATED PLAN OF ACTION TO REMOVE IMMEDIATE JEOPARDY</p> <ol style="list-style-type: none"> 1) Consumer #1 has been moved / relocated to [second hotel placement in a neighboring town], separating him from his roommates, and eliminating the need for them to fear him. 2) Consumer #1 will be double staffed during waking hours and one on one during sleeping hours with immediate access to a 2nd staff if he wakes up, to protect him from environmental dangers, injury, and elopement. 3) BDDS (Bureau of Developmental Disabilities Services) has been contacted in an effort to expedite the LOC (Level of Care) needed for Consumer #1 to be placed in an ESN (Extensive Support Needs) home. 4) We will continue to seek alternative, and ESN placement for long term assistance. 5) Consumer #1 will not be returning to the [name of town] Group Home." 		<p>rights and grievance policies to all consumers upon admission and annually. (ATTACHMENT F)The facility will obtain a Behavior Consultant for client #1. (ATTACHMENT G)A new functional assessment will be completed for client #1. (ATTACHMENT H)A new Behavior Plan for client #1 will be written, trained/Implemented for all necessary staff. (ATTACHMENT I)Client #1 will be housed elsewhere while alternate placement is located. He will not return to this group home. (ATTACHMENT E)Client #1 will be staffed 2:1 @ all times. (ATTACHMENT E)The facility will investigate all reportable incidents; any substantiated incidents will be addressed through programming goal, behavior modification goals, and necessary steps to protect the rights of all individuals. (ATTACHMENT J)Administrative Team will make appropriate recommendations for any corrective action needed. (ATTACHMENT J)Consumer's IDT will convene to discuss the outcome/recommendations from Appropriate Parties. (ATTACHMENT K)All corrective measures recommended by Appropriate Parties and reviewed and approved by IDT will be written in ISP/BSP trained and implemented. (ATTACHMENT K) How we will identify others: The Clinical Supervisor will review</p>				

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	<p>Program Director/PD #2 and OM/Operations Manager #1 were notified the Immediate Jeopardy had been removed as of 9/4/13. The removal was based on the assurance client #1 would not be returning to the residential facility. PD #2 and OM #1 were notified at the exit conference on 9/4/13 the facility remained at the Condition of Participation level of non-compliance due to the facility's failure to secure appropriate placement for the client and the behavioral evaluation by a degreed behaviorist had not yet been accomplished.</p> <p>Findings include:</p> <p>Please refer to W149 for 4 of 4 sampled clients (#1, #2, #3 and #4), plus 3 additional clients (#5, #6, and #7), for the facility's failure to implement written policies and procedures which prohibited mistreatment, neglect or abuse of clients.</p> <p>Please refer to W157 for 7 of 10 reportable incidents/investigations reviewed affecting 4 of 4 sampled clients (#1, #2, #3 and #4), plus 3 additional clients (#5, #6, and #7), for the facility's failure to implement corrective procedures to address client #1's ongoing behavioral issues (intimidation), neglect or psychological abuse of his housemates</p>		<p>all behavior and incident documentation weekly to identify like issues. (ATTACHMENT L)The Clinical Supervisor will review all plans to ensure all client trainings are completed. (ATTACHMENT M)Clinical Supervisor will do a functional assessment at admission and annually for each consumer to identify specific individual needs in behavior management, and ADL's/Goals. Appropriate Parties will investigate all alleged incidents per policy and procedure. (ATTACHMENT J)Appropriate Parties will make appropriate recommendations for any corrective action needed. (ATTACHMENT J)Consumer's IDT will convene to discuss the outcome/recommendations from Appropriate Parties. (ATTACHMENT K&N) Measures to be put in place:The Clinical Supervisor will ensure all staff have been trained on client's rights and protections, and have been trained on abuse and neglect. (ATTACHMENT A,B,& C) The Clinical Supervisor will review all plans to ensure all client trainings are completed. (ATTACHMENT M)Clinical Supervisor will implement/train plan addendums when an identified issue is determined. (ATTACHMENT O)The Clinical Supervisor will conduct monthly meetings and review for all staff: behavior documentation, incidents reportable and internal,</p>				

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	and the failure to protect him from harm by preventing his eloping and causing injury to his head/face/teeth. 9-3-2(a)		abuse and neglect definition, ResCare policy on abuse and neglect, reporting, Client rights and protections, and review of ISP, BSP, and HRP. (ATTACHMENT P)All staff will attend an YSIS recertification training annually. (ATTACHMENT D)Clinical Supervisor will ensure all incidents are documented and reported to Appropriate Parties. (ATTACHMENT J)Appropriate Parties will follow policy and procedures for all reported incidents. (ATTACHMENT J)Consumer's will attend monthly client council meetings to discuss agency activities, grievance procedures, medical options, responsibilities, home and community safety, community activities, living options, rights, self-advocacy, and nutrition.. (ATTACHMENT Q) Monitoring of Corrective Action:Operations Manager and Program Manager will conduct Best in Class, and periodic reviews to ensure all policies and procedures are being followed.Operations Manager and Appropriate Parties will review all ISP's, BSP'S, and all addendums before training and implementation.		

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W000149	<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. Based on observation, record review, and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), plus 3 additional clients (#5, #6, and #7), the facility failed to implement written policies and procedures which prohibited mistreatment (intimidation), neglect or psychological abuse of clients.</p> <p>Findings include:</p> <p>Observations were conducted at the facility's day program on the afternoon of 8/26/13 from 2:00 PM until 4:00 PM. Upon entrance to the day program's classroom, five male individuals from the facility (#2, #3, #4, #5, and #6) were engaged in activities. When asked if all facility clients were present, workshop staff #3 indicated clients #1 and #7 were absent. Client #4 indicated client #7 had an appointment and client #1 did not attend a day program/workshop. Client #2 stated, "[Client #1] is a trouble maker."</p> <p>Interview with workshop supervisory/WS staff #1 on 8/26/13 at 3:30 PM indicated client #1 was admitted to the residential facility in April of 2013 and had visited the day program/workshop. Client #1</p>	W000149	<p>Corrective action: The facility will train/inserve all staff at this location and Day Program designee on policies and procedures concerning client neglect and abuse, the definition of all types of abuse including verbal abuse, emotional abuse, intimidation, and psychological abuse. (ATTACHMENT A&B) The facility will train/inserve all staff at this location and Day Program designee on policies and procedures concerning client rights and protections. (ATTACHMENT B&C)The facility will train/inserve YSIS (You're Safe, I'm Safe) Physical Safety techniques, and behavior management crisis resolution to all staff at this location during orientation, and annually for recertification. (ATTACHMENT D)The facility will relocate client #1, housing him away from previous housemates, eliminating his ability to endanger either the physical, psychological, or emotional health. (ATTACHMENT E&R)This facility will make available to all residents of this group home additional counseling/ therapy as needed or requested to ensure the continued positive mental and psychological health. (ATTACHMENT E&S)The</p>	09/23/2013	

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	<p>began formal attendance of the workshop 5/1/13. He had a behavior that was redirectable by male workshop supervisor #4 on 5/2/13 and the facility's clinical supervisor/CS #1 picked him up when client #1 indicated he wanted to go home. Client #1 had a behavior episode at the workshop on 5/6/13 wherein he threatened and attacked a female peer and the female workshop staff (male supervisor was absent). CS #1 arrived to offer assistance and after surveying the situation; local law enforcement was called for assistance as client #1 was "out of control."</p> <p>Observations were conducted at the facility on the afternoon of 8/26/13 from 4:05 PM until 5:50 PM. Clients #1, #2, #3, #4, #5, #6 and #7 were present along with staff CS #1, current home manager/HM #5, and Support Associates/SAs #4, #5 and #6. Client #2 was cooking dinner and supervised by SA #6. Client #1 was in his bedroom and later came out to greet the visitor and discuss a recent mishap when he injured his front two teeth. Client #1 had visible marks to his nose and left thumb area. He was redirected by staff to sit at the dining table and engage in activities (coloring). Clients and SA staff ate the evening meal of spaghetti, salad, garlic bread, beverages and fruit at 5:10 PM. Client #1 sat beside</p>		<p>facility will train/inserve Client rights and grievance policies to all consumers upon admission and annually. (ATTACHMENT F)The facility will obtain a Behavior Consultant for client #1. (ATTACHMENT G)A new functional assessment will be completed for client #1. (ATTACHMENT H)A new Behavior Plan for client #1 will be written, trained/Implemented for all necessary staff. (ATTACHMENT I)Client #1 will be housed elsewhere while alternate placement is located. He will not return to this group home. (ATTACHMENT E)Client #1 will be staffed 2:1 @ all times. (ATTACHMENT E)The facility will investigate all reportable incidents; any substantiated incidents will be addressed through programming goal, behavior modification goals, and necessary steps to protect the rights of all individuals. (ATTACHMENT J)Administrative Team will make appropriate recommendations for any corrective action needed. (ATTACHMENT J)Consumer's IDT will convene to discuss the outcome/recommendations from Appropriate Parties. (ATTACHMENT K)All corrective measures recommended by Appropriate Parties and reviewed and approved by IDT will be written in ISP/BSP trained and implemented. (ATTACHMENT K) How we will identify others:</p>				

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	<p>SA #4 (only male staff currently employed at the facility) and continued to talk throughout his meal, even as he chewed his food.</p> <p>Observations were conducted at the facility on 8/27/13 from 6:30 AM until 8:50 AM and from 11:00 AM until 3:00 PM. Client #1 did not go to the workshop with clients #2, #3, #4, #5, #6 and #7 at 8:30 AM. CS #1, HM #5 and SA #8 were at the facility with client #1. HM #5 had to leave the facility at 2:00 PM, but staff #9 came to take her place. At 1:30 PM on 8/27/13, client #1 indicated to the surveyor he had needed dental restoration of his front two teeth after he had fallen in the community.</p> <p>Documents provided by the day services/DS staff #1 were reviewed on 8/27/13 at 9:30 AM. An incident report dated 5/6/13 at 1:55 PM by DS #1 indicated in part..."911 was called and the 1 [local city] policeman arrived. The policeman tried to talk [client #1] down. [Client #1] kept trying to get a computer to work. [Client #1] would not calm down. The police turned his red tazer light on and told [client #1] he did not want to use it. The policeman left the workshop area to call for a 2nd police. A second police arrived. [Client #1] resisted them. The Police told [client #1] several</p>		<p>The Clinical Supervisor will review all behavior and incident documentation weekly to identify like issues. (ATTACHMENT L)The Clinical Supervisor will review all plans to ensure all client trainings are completed. (ATTACHMENT M)Clinical Supervisor will do a functional assessment at admission and annually for each consumer to identify specific individual needs in behavior management, and ADL's/Goals. Appropriate Parties will investigate all alleged incidents per policy and procedure. (ATTACHMENT J)Appropriate Parties will make appropriate recommendations for any corrective action needed. (ATTACHMENT J)Consumer's IDT will convene to discuss the outcome/recommendations from Appropriate Parties. (ATTACHMENT K&N) Measures to be put in place:The Clinical Supervisor will ensure all staff have been trained on client's rights and protections, and have been trained on abuse and neglect. (ATTACHMENT A,B,& C) The Clinical Supervisor will review all plans to ensure all client trainings are completed. (ATTACHMENT M)Clinical Supervisor will implement/train plan addendums when an identified issue is determined. (ATTACHMENT O)The Clinical Supervisor will conduct monthly meetings and review for all staff: behavior documentation,</p>				

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	<p>times to put his hands behind him, he did not. A policeman put [client #1] on the floor. [Client #1] continued to fight and would not lay still. A policemen used the tazer on [client #1]. Completed handcuffing, talked to (sic) [client #1]. 2 county sheriff (sic) deputies arrived, they talked to [client #1] as he sat on a chair. [Client #1] told them he had been tazed before. EMT's (sic) (Emergency Medical Technicians) arrived and checked [client #1]. The police took custody of [client #1]. We gave them medical information. [CS #1]...said she would follow them to the hospital."</p> <p>Client #1 was suspended from the day program and he was sent a letter dated 5/8/13 which outlined the behavior episode which led to his suspension. The behavior was precipitated by workshop staff intervening (disabling the Internet access) when client #1 accessed a pornographic website.</p> <p>The letter dated 5/8/13 was reviewed on 8/27/13 at 9:30 AM and indicated the following: "On May 6th, 2013 you were observed physically attacked (sic) a fellow client, grabbing her from behind while she was seated and holding her down while you attempted to forcefully kiss her while at the same time you thrust your lower body</p>		<p>incidents reportable and internal, abuse and neglect definition, ResCare policy on abuse and neglect, reporting, Client rights and protections, and review of ISP, BSP, and HRP. (ATTACHMENT P)All staff will attend an YSIS recertification training annually. (ATTACHMENT D)Clinical Supervisor will ensure all incidents are documented and reported to Appropriate Parties. (ATTACHMENT J)Appropriate Parties will follow policy and procedures for all reported incidents. (ATTACHMENT J)Consumer's will attend monthly client council meetings to discuss agency activities, grievance procedures, medical options, responsibilities, home and community safety, community activities, living options, rights, self-advocacy, and nutrition.. (ATTACHMENT Q) Monitoring of Corrective Action:Operations Manager and Program Manager will conduct Best in Class, and periodic reviews to ensure all policies and procedures are being followed.Operations Manager and Appropriate Parties will review all ISP's, BSP'S, and all addendums before training and implementation.</p>				

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	<p>into her side. When staff intervened you refused to stop until they physically removed you from her. As they attempted to pull you off her, you said you would 'rape her, rip her clothes off and rape her.' Next you threatened the three female staff who had rescued her by threatening to rip off their clothes and rape them. As you advanced upon one of the staff another intervened to keep you from physically assaulting her and you struck that staff person in the mouth with your fist. You then attempted to return to a pornographic web site which you had previously accessed (unknown to staff) on the company computer which is available for client use. When you were instructed to stop this activity because it was inappropriate at work and a violation of policy, you refused to stop your efforts. When the machine was unplugged by staff, you sought out pictures of women in nearby magazines and commenced making lewd comments about them and doing lewd suggestive things to the photos.</p> <p>When Police were called and attempted to talk to you, you refused to cooperate with their requests or later with their direction and provoked a physical confrontation. These actions on your part have clearly and seriously endangered the safety and well being of other persons in our care and/or employment and are in direct</p>			

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	<p>violation of agency policy.</p> <p>Incident reports have been sent to you and your residential provider outlining the details of these infractions. To insure the safety of all concerned you are suspended from service effective today and until such time as an Interdisciplinary team can meet to determine an appropriate plan to best meet your needs and insure the safety and well being of all clients and staff..."</p> <p>The Interdisciplinary team (IDT) meeting was held on 5/10/13 and client #1's workshop services were terminated.</p> <p>Interview with WS #1 and Work Services Director/WSD #2 on 8/27/13 at 10:08 AM indicated their workshop building also accommodated a preschool class of eight 3 to 5 year old special needs children during the academic school year. The staff indicated client #1 remained on a type of permanent suspension and cited the presence of vulnerable children as a contributing factor to his continued absence. Work Services Director #2 expressed his concern for client #1's special needs in the areas of inappropriate sexual behavior (threatening rape of women) the need for structure, supervision and behavior modification. The interview indicated the present residential placement and day program currently available could not meet client #1's individual needs. Work Services</p>						

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	<p>Director #2 stated: "The system is letting this young man down and exposing the community to a hazard. [Client #1] needs a more intensive level of care."</p> <p>Review of facility incident reports and Bureau of Developmental Disabilities Services/BDDS reports on 8/27/13 at 9:30 AM and at 2:15 PM and on 8/28/13 at 12:00 PM indicated the following:</p> <p>1. A BDDS report dated 5/2/13 indicated an incident on 5/1/13 at 8:30 PM wherein client #1 became upset about the fruit salad that was served as the evening snack.</p> <p>Client #1 complained there were nuts in the fruit salad but there were not. Reasoning/redirection failed and client #1 threatened staff with a knife. The incident report by staff #4 indicated client #1 "started yelling at clients" (clients #2, #4, #5, #6 and #7). He chased staff #13 out the back door (wielding the knife). The police were called (by the neighbors) and offered assistance but were told things were calm and under control. When the police car pulled away, client #1 struck former house manager #12 in the back and face. Client #1's behaviors required two physical restraints; one lasting 2 1/2 minutes and the second lasting 3 minutes. The BDDS report indicated client #1 had sustained "some minor injuries from the</p>						

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	<p>behavioral outburst."</p> <p>A 5/2/13 time unknown nursing note by LPN #1 was attached to the BDDS report and indicated "minor injuries."</p> <p>LPN #1 assessed client #1 and documented he had "on (left) outside forearm 1 inch scratch. Various red scratch marks on mid (middle) back ranges from approx (approximately) 1/2 inch - 1/12/ in (inch) - (7 red marks noted) (Left) shoulder (lower) back of arm pit approx 1 1/2 in noted scratched area [not] open (right) shoulder - petichaie (sic) (petechaie: small round reddish spots appearing in clusters like a rash caused by bleeding under the skin/minor blood vessel injuries) noted on top of shoulder. face red (with) petichaie (sic) noted over all of client's face as well. Both eyes appear slightly swollen (with)...petichaie (sic) on upper eye lids (and) below eyes. Noted darkness under both eyes. Noted an approx. 2 1/2 in scratch on (right) side of nose. Noted petichaie (sic) on bil (bilateral) side of neck on front of neck (and) behind bil ears to hairline - Noted 2 old scars on (right lower) under arm from old bandages from previous placement."</p> <p>An unsigned investigation conducted by facility administrative staff (unknown) was initiated/dated 5/2/13 at 7:15 PM. This document was reviewed 8/28/13 at 8:00 PM. The investigation was initiated</p>			
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	<p>to ascertain the facts surrounding client #1's behavioral outburst of 5/1/13 and how he may have received the "minor" injuries as documented by LPN #1. The investigative report's "Summary of evidence" component indicated:</p> <p>"Witness statements and documents relevant to the investigation were collected and reviewed. Review of [client #1's] BSP (Behavior Support Plan) indicates that restrictive strategies when [client #1] engages in physical aggression are to go to 1:1 staff (one staff assigned to the client) at first sign of being upset, take him for a walk, encourage him to call family or friend to discuss what is upsetting him, and to use Advanced YSIS (You're Safe I'm Safe/agency approved and taught behavior management techniques) if he is showing signs of harm to himself or others. Review of his BSP further indicates that if [client #1] exhibits SIB (Self Injurious Behavior) staff will use YSIS if needed...Review of nurse's assessment reveals the presence of numerous scratches and areas of 'rug burn' over [client #1's] face and shoulders. Witness statements reveal that while staff did not implement YSIS as trained, they did not contribute to the minor injuries sustained in this incident."</p> <p>The investigation's "Conclusion and</p>			

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	<p>Findings" component indicated: "After review of all statements and information collected, it is the consensus of the investigation committee (persons unknown) that there was no violation of ResCare Policy. It is further determined that YSIS was not implemented in accordance with the training provided."</p> <p>Confidential interview D indicated former Operations Manager #2 investigated the 5/1/13 incident with client #1 and was the author of the unsigned 5/2/13 investigative report quoted above. The interview indicated the information regarding client #1's stabbing former house manager #12 with a potato peeler was left out of the investigative report for an unknown reason.</p> <p>Interview with client #3 on 8/26/13 at 4:15 PM during a routine environmental tour of his bedroom accommodations expressed concern regarding his new housemate, client #1. Client #3 stated client #1 was "mean to everybody...he stabbed [staff #12, former house manager]." When asked if he was afraid of client #1, client #3 stated, "No, I hit him."</p> <p>The current house manager/HM, staff #5, was interviewed on 8/27/13 at 8:45 AM to clarify the statements of 8/26/13 by</p>						

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	<p>client #3. The interview indicated client #3 was the only client residing in the facility who was not fearful of client #1 and he was expressing his confidence in being able to defend himself if attacked; he had not actually hit client #1. HM #5 stated "all the men (clients #2, #4, #5, #6 and #7) are afraid except (client #3)" of client #1.</p> <p>2. A BDDS report dated 5/6/13 with incident date of 5/6/13 at 2:05 PM indicated the above behavioral episode as outlined by Workshop supervisory staff #1's report of the incident in the letter dated 5/8/13 previously quoted.</p> <p>3. A BDDS report dated 6/7/13 with incident date of 6/7/13 at 7:15 AM indicated client #1 eloped from the facility after it was discovered he had stolen an iPad out of staff's purse. Client #1 was sitting on his bed with the iPad underneath him. Staff retrieved the iPad. Client #1 ran out of the house but "staff could not keep up with him. Staff got in the van to follow him but he was out of sight. Staff found him at the intersection about a mile from the home. He was out of eyesight of staff for about 10 minutes. At the intersection he was standing in the road. Staff parked the van, called the police and proceeded to attempt to get him in the van. Police arrived, restrained</p>						

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	<p>him on the ground and placed him in handcuffs to ensure his safety. Police told staff they had also received a call from a lady that reported [client #1] had accosted her in the parking lot as she was going to work." HM #5's witness statement attached to the BDDS report indicated the "lady" was a paralegal who had freed herself from client #1 and locked herself in her car.</p> <p>Confidential interview A indicated client #1 had eloped from the facility in June 2013 and sexually assaulted a local lady in the community by grabbing at her chest and telling her "I am going to rip off your clothes and rape you."</p> <p>4. A BDDS report dated 6/27/13 with incident date of 6/27/13 at 7:45 AM indicated client #1 was sitting at the dining room table and wanted to stand up. Client #2 was looking at the posted chore chart and client #1 became upset and was cursing peers (Clients #2 and #7) and staff. Client #1 went into the kitchen and yelled and cursed and threw a plate at TL (Team Leader) #3. Client #1 reached into a drawer obtaining a table/butter knife and threatened TL #3 with it. Staff attempted verbal redirection, but client #1 ran out the facility's backdoor. Staff pursued him in the van. Staff kept him in eyesight but were unable to convince him</p>						

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	<p>to put down the "butter knife" and get into the van. Staff called the police for assistance. "When the police arrived [client #1] was calm and agreed he would return to the group home."</p> <p>5. A BDDS report dated 7/25/13 with incident date of 7/24/13 at 5:15 PM indicated staff was assisting client #1 with cleaning his room and asked him to obtain some cleaning supplies to clean stains from the walls. Client #1 became "agitated and began screaming and cursing at staff threatening to kill her. He picked up his room mate's belt and swung the buckle end at the staff; she ducked the the blow and and closed the bedroom door. [Client #1] continued screaming and striking the wall and the door with the belt buckle, stating that he would kill them all and get blood all over the walls. Staff could not intervene (sic) his behavior and called the police for assistance; police responded and requested that [client #1's] therapist be contacted. Police spoke with [client #1's] therapist and the therapist requested that the police escort [client #1] to the [name of behavioral unit]. Police complied and [client #1] was taken inpatient for observation and treatment."</p> <p>The internal incident (7/24/13 at 5:00 PM) report which generated the BDDS</p>						

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	<p>report indicated 4 facility staff were present at the time of behavioral outburst. Client #1 had been asked to get some "hot water with soap" to clean the bedroom wall. His bed was beside the wall and "there was all kinds of sperm (and) spit all over the wall where his bed had been (sic)." The BDDS follow up report indicated client #1 was released from the behavioral unit on 8/2/13 and some of his behavioral medications were changed. He was to continue weekly therapy sessions on an outpatient basis.</p> <p>6. A BDDS report dated 8/8/13 with incident date of 8/8/13 at 9:17 AM indicated client #1 had eloped from the facility and SA #8 and HM #5 pursued him in the facility van. CS #1 observed the pursuit and followed as well. Client #1 ran through the community toward a busy state highway, fell injuring his face and teeth (was bloody) at a local gas station. The client jumped up and ran "another two blocks" west on the highway in and out of traffic without using pedestrian safety skills. The BDDS report indicated client #1 had become upset when he was asked to use soap as he washed his hands. Staff were able to "corral" him and determined he had two 2 inch lacerations (nose and chin) on his face, "several teeth in the front of his mouth appeared loose and his two front</p>						

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	<p>teeth were chipped in a moon shape." Facility staff took him to a local emergency room for treatment.</p> <p>During interview with client #2 on 8/27/13 at 6:30 AM, he stated: "[Client #1] is bossy to staff. Scared of him, afraid he'll hit me. Takes CDs (compact discs) and my clothes."</p> <p>Review of client #2's record on 8/28/13 at 12:15 PM, included an IDT dated 5/8/13 which indicated client #2 was client #1's room-mate. Client #2 expressed his dissatisfaction in having client #1 as a room-mate and requested a change. The IDT indicated, "[Client #2] is afraid he will be attacked while sleeping by client (client #1). CS (clinical supervisor) reassured [client #2] that bedchecks are done every hour during sleep hours and he will be protected, at all times. [Client #2] asked to be moved out of that bedroom...." The IDT indicated due to the nature of the facility (two story, four bedroom dwelling with small living/dining area) client #2's request could not be accommodated.</p> <p>Team Leader staff #9, who works alone with clients during the night shift 11:00 PM to 6:00 AM, was interviewed on 8/27/13 at 6:25 AM. Staff #9 stated "[Client #1] can run like a deer, there is</p>				

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	<p>no stopping him" when he decides to elope.</p> <p>During a conversation with client #1 on 8/28/13 at 12:00 PM he was asked how he happened to have some marks on his nose and left thumb area and was asked to clarify earlier statements (8/27/13 1:30 PM) regarding some dental work he had done to his front teeth. Client #1 stated "I went AWOL (absent without leave/left the facility without permission) fell [name of gas] station. (sic) Went AWOL before had behavior at [day program site] went to [name of town] security facility." Client #1 stated (named the sheriff's deputy and spelled his surname for the surveyor) "tased me once. [The deputy] took me to [name of behavioral unit] in [name of city]." Client #1 was verbally redirected back to the gas station incident and the injuries to his face/teeth; he indicated he was running and fell down in the parking area of the gas station because he was not looking where he was going. When asked if he paid attention to the heavy traffic (on the nearby state highway) client #1 stated he used "profanity, the 'F' word, did not look and ran toward [name of town] (town west of the residential facility on a state highway, a heavily traveled road). Client #1 was reminded this highway was heavily traveled by semi-trailer trucks and</p>						

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	<p>assorted other vehicles and it could be dangerous for him to be running across the highway without caution as he did on 8/8/13. Client #1 stated "I'm glad they weren't drunk."</p> <p>Review of agency policies and procedures on 8/28/13 at 3:45 PM indicated a Standard Operating Procedure for Identifying and Reporting Suspected Abuse and Neglect dated 7/18/11. The review indicated the agency prohibited client abuse and neglect. Definitions were in an undated policy used for staff training purposes:</p> <p>"Neglect means the failure of an individual to provide the treatment care, goods or services that are necessary to maintain the health or safety of a person we support."</p> <p>9-3-2(a)</p>				

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review, and interview of 7 of 10 reportable incidents/investigations reviewed affecting 4 of 4 sampled clients (#1, #2, #3 and #4), plus 3 additional clients (#5, #6, and #7), the facility failed to implement corrective procedures to address client #1's ongoing behavioral issues (intimidation), neglect or psychological abuse of his housemates and day program co-workers.</p> <p>Findings include:</p> <p>I. Review of facility incident reports and Bureau of Developmental Disabilities Services/BDDS reports on 8/27/13 at 9:30 AM and at 2:15 PM and on 8/28/13 at 12:00 PM indicated the following:</p> <p>A BDDS report dated 5/2/13 indicated an incident on 5/1/13 at 8:30 PM wherein client #1 became upset about the fruit salad that was served as the evening snack. Client #1 complained there were nuts in the fruit salad but there were not. Reasoning/redirection failed and client #1 threatened staff with a knife. The incident report by staff #4 indicated client #1 "started yelling at clients" (clients #2, #4,</p>	W000157	<p>Corrective action:The facility will train/inservice all staff at this location and Day Program designee on policies and procedures concerning client neglect and abuse, the definition of all types of abuse including verbal abuse, emotional abuse, intimidation, and psychological abuse. (ATTACHMENT A&B) The facility will train/inservice all staff at this location and Day Program designee on policies and procedures concerning client rights and protections. (ATTACHMENT B&C) The facility will train/inservice YSIS (You're Safe, I'm Safe) Physical Safety techniques, and behavior management crisis resolution to all staff at this location during orientation, and annually for recertification. (ATTACHMENT D) The facility will relocate client #1, housing him away from previous housemates, eliminating his ability to endanger either the physical, psychological, or emotional health. (ATTACHMENT E&R) This facility will make available to all residents of this group home additional counseling/ therapy as needed or requested to ensure the continued positive mental and psychological health. (ATTACHMENT E&S) The facility will train/inservice Client</p>	09/23/2013			

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	<p>#5, #6 and #7). He chased staff #12 out the back door (wielding the knife). The police were called (by the neighbors) and offered assistance but were told things were calm and under control. When the police car pulled away, client #1 struck former house manager #13 in the back and face. Client #1's behaviors required two physical restraints; one lasting 2 1/2 minutes and the second lasting 3 minutes. The BDDS report indicated client #1 had sustained "some minor injuries from the behavioral outburst."</p> <p>A 5/2/13 time unknown nursing note by LPN #1 was attached to the BDDS report indicated the "minor injuries." LPN #1 assessed client #1 and documented he had "on (left) outside forearm 1 inch scratch. Various red scratch marks on mid (middle) back ranges from approx (approximately) 1/2 inch - 1/12/ in (inch) - (7 red marks noted) (Left) shoulder (lower) back of arm pit approx 1 1/2 in noted scratched area [not] open (right) shoulder - petichaie (sic) (petechaie: small round reddish spots appearing in clusters like a rash caused by bleeding under the skin/minor blood vessel injuries) noted on top of shoulder. face red (with) petichaie (sic) noted over all of client's face as well. Both eyes appear slightly swollen (with)...petichaie on upper eye lids (and) below eyes.</p>		<p>rights and grievance policies to all consumers upon admission and annually. (ATTACHMENT F)The facility will obtain a Behavior Consultant for client #1. (ATTACHMENT G)A new functional assessment will be completed for client #1. (ATTACHMENT H)A new Behavior Plan for client #1 will be written, trained/implemented for all necessary staff. (ATTACHMENT I)Client #1 will be housed elsewhere while alternate placement is located. He will not return to this group home. (ATTACHMENT E)Client #1 will be staffed 2:1 @ all times. (ATTACHMENT E)The facility will investigate all reportable incidents; any substantiated incidents will be addressed through programming goal, behavior modification goals, and necessary steps to protect the rights of all individuals. (ATTACHMENT J)Administrative Team will make appropriate recommendations for any corrective action needed. (ATTACHMENT J)Consumer's IDT will convene to discuss the outcome/recommendations from Appropriate Parties. (ATTACHMENT K)All corrective measures recommended by Appropriate Parties and reviewed and approved by IDT will be written in ISP/BSP trained and implemented. (ATTACHMENT K) How we will identify others: The Clinical Supervisor will review</p>				

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	<p>Noted darkness under both eyes. Noted an approx. 2 1/2 in scratch on (right) side of nose. Noted petichiae (sic) on bil (bilateral) side of neck on front of neck (and) behind bil ears to hairline - Noted 2 old scars on (right lower) under arm from old bandages from previous placement."</p> <p>An unsigned investigation conducted by facility administrative staff (unknown) was initiated/dated 5/2/13 at 7:15 PM. This document was reviewed 8/28/13 at 8:00 PM. The investigation was initiated to ascertain the facts surrounding client #1's behavioral outburst of 5/1/13 and how he may have received the "minor" injuries as documented by LPN #1. The investigative report's "Summary of evidence" component indicated:</p> <p>"Witness statements and documents relevant to the investigation were collected and reviewed. Review of [client #1's] BSP (Behavior Support Plan) indicates that restrictive strategies when [client #1] engages in physical aggression are to go to 1:1 staff (one staff assigned to the client) at first sign of being upset, take him for a walk, encourage him to call family or friend to discuss what is upsetting him, and to use Advanced YSIS (You're Safe I'm Safe/agency approved and taught behavior management techniques) if he is showing signs of harm</p>		<p>all behavior and incident documentation weekly to identify like issues. (ATTACHMENT L)The Clinical Supervisor will review all plans to ensure all client trainings are completed. (ATTACHMENT M)Clinical Supervisor will do a functional assessment at admission and annually for each consumer to identify specific individual needs in behavior management, and ADL's/Goals. Appropriate Parties will investigate all alleged incidents per policy and procedure. (ATTACHMENT J)Appropriate Parties will make appropriate recommendations for any corrective action needed. (ATTACHMENT J)Consumer's IDT will convene to discuss the outcome/recommendations from Appropriate Parties. (ATTACHMENT K&N) Measures to be put in place:The Clinical Supervisor will ensure all staff have been trained on client's rights and protections, and have been trained on abuse and neglect. (ATTACHMENT A,B,& C) The Clinical Supervisor will review all plans to ensure all client trainings are completed. (ATTACHMENT M)Clinical Supervisor will implement/train plan addendums when an identified issue is determined. (ATTACHMENT O)The Clinical Supervisor will conduct monthly meetings and review for all staff: behavior documentation, incidents reportable and internal,</p>				

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	<p>to himself or others. Review of his BSP further indicates that if [client #1] exhibits SIB (Self Injurious Behavior) staff will use YSIS if needed...Review of nurse's assessment reveals the presence of numerous scratches and areas of 'rug burn' over [client #1's] face and shoulders. Witness statements reveal that while staff did not implement YSIS as trained, they did not contribute to the minor injuries sustained in this incident."</p> <p>The investigation's "Conclusion and Findings" component indicated: After review of all statements and information collected, it is the consensus of the investigation committee (persons unknown) that there was no violation of ResCare Policy. It is further determined that YSIS was not implemented in accordance with the training provided."</p> <p>Interview with workshop supervisory/WS staff #1 on 8/26/13 at 3:30 PM indicated client #1's former house manager/HM staff #12 had been to the workshop to pickup clients (date unknown) and workshop staff had noticed a blackened eye. When asked about his black eye, HM #12 indicated client #1 had hit him and he showed workshop staff an injury said to be caused by being attacked with a potato peeler by client #1 during the same behavioral outburst (5/1/13 8:30 PM).</p>		<p>abuse and neglect definition, ResCare policy on abuse and neglect, reporting, Client rights and protections, and review of ISP, BSP, and HRP. (ATTACHMENT P)All staff will attend an YSIS recertification training annually. (ATTACHMENT D)Clinical Supervisor will ensure all incidents are documented and reported to Appropriate Parties. (ATTACHMENT J)Appropriate Parties will follow policy and procedures for all reported incidents. (ATTACHMENT J)Consumer's will attend monthly client council meetings to discuss agency activities, grievance procedures, medical options, responsibilities, home and community safety, community activities, living options, rights, self-advocacy, and nutrition.. (ATTACHMENT Q) Monitoring of Corrective Action: Operations Manager and Program Manager will conduct Best in Class, and periodic reviews to ensure all policies and procedures are being followed. Operations Manager and Appropriate Parties will review all ISP's, BSP'S, and all addendums before training and implementation.</p>				

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	<p>Interview with client #3 on 8/26/13 at 4:15 PM during a routine environmental tour of his bedroom accommodations, client #3 expressed concern regarding his new housemate, client #1. Client #3 stated client #1 was "mean to everybody...he stabbed [staff #12, former house manager]." When asked if he was afraid of client #1, client #3 stated, "No, I hit him."</p> <p>The current house manager/HM, staff #5, was interviewed on 8/27/13 at 8:45 AM to clarify the statements of 8/26/13 by client #3. The interview indicated client #3 was the only client residing in the facility who was not fearful of client #1 and he was expressing his confidence in being able to defend himself if attacked; he had not actually hit client #1. HM #5 stated "all the men (clients #2, #4, #5, #6 and #7) are afraid except (client #3)" of client #1.</p> <p>Confidential interview A indicated former Operations Manager #2 investigated the 5/1/13 incident with client #1 and was the author of the unsigned 5/2/13 investigative report quoted above. The interview indicated the information regarding client #1's stabbing former house manager #12 with a potato peeler was left out of the investigative report for some unknown reason.</p>						

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	<p>II.</p> <p>Review of facility incident reports and Bureau of Developmental Disabilities Services/BDDS reports on 8/27/13 at 9:30 AM and at 2:15 PM and on 8/28/13 at 12:00 PM indicated the following:</p> <p>A BDDS report dated 5/6/13 with incident date of 5/6/13 at 2:05 PM indicated a behavioral episode with client #1 at the day program as reported by Workshop Supervisory/WS staff #1 who witnessed the incident and was one of the alleged victims of client #1. The following information summarizes the events depicted in the BDDS report of 5/6/13:</p> <p>Client #1 was suspended from the day program and he was sent a letter dated 5/8/13 which outlined the behavior episode which led to his suspension. The behavior was precipitated by workshop staff intervening (disabling the Internet access) when client #1 accessed a pornographic website.</p> <p>The letter dated 5/8/13 was reviewed on 8/27/13 at 9:30 AM and indicated the following:</p> <p>"On May 6th, 2013 you were observed physically attacked (sic) a fellow client, grabbing her from behind while she was seated and holding her down while you</p>						

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	<p>attempted to forcefully kiss her while at the same time you thrust your lower body into her side. When staff intervened you refused to stop until they physically removed you from her. As they attempted to pull you off her, you said you would 'rape her rip her clothes off and rape her.' Next you threatened the three female staff who had rescued her by threatening to rip off their clothes and rape them. As you advanced upon one of the staff another intervened to keep you from physically assaulting her and you struck that staff person in the mouth with your fist. You then attempted to return to a pornographic web site which you had previously accessed (unknown to staff) on the company computer which is available for client use. When you were instructed to stop this activity because it was inappropriate at work and a violation of policy, you refused to stop your efforts. When the machine was unplugged by staff, you sought out pictures of women in nearby magazines and commenced making lewd comments about them and doing lewd suggestive things to the photos.</p> <p>When Police were called and attempted to talk to you, you refused to cooperate with their requests or later with their direction and provoked a physical confrontation. These actions on your part have clearly and seriously endangered the safety and</p>			

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	<p>well being of other persons in our care and/or employment and are in direct violation of agency policy.</p> <p>Incident reports have been sent to you and your residential provider outlining the details of these infractions. To insure the safety of all concerned you are suspended from service effective today and until such time as an Interdisciplinary team can meet to determine an appropriate plan to best meet your needs and insure the safety and well being of all clients and staff...."</p> <p>Observations were conducted at the facility's day program on the afternoon of 8/26/13 from 2:00 PM until 4:00 PM. Upon entrance to the day program's classroom, five male individuals from the facility (clients #2, #3, #4, #5, and #6) were engaged in activities. When asked if all facility clients were present, workshop staff #3 indicated clients #1 and #7 were absent. Client #4 indicated client #7 had an appointment and client #1 did not attend a day program/workshop. Client #2 stated, "[Client #1] is a trouble maker."</p> <p>Interview with workshop supervisory/WS staff #1 on 8/26/13 at 3:30 PM indicated client #1 was admitted to the residential facility in April of 2013 and had visited the day program/workshop. Client #1 began formal attendance of the workshop 5/1/13. He had a behavior that was</p>			

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	<p>redirectable by male workshop supervisor #4 on 5/2/13 and the facility's clinical supervisor/CS #1 picked him up when client #1 indicated he wanted to go home. Client #1 had a behavior episode at the workshop on 5/6/13 wherein he threatened and attacked a female peer and the female workshop staff (male supervisor was absent). CS #1 arrived to offer assistance and after surveying the situation; local law enforcement was called for assistance as client #1 was "out of control."</p> <p>Observations were conducted at the facility on the afternoon of 8/26/13 from 4:05 PM until 5:50 PM. Clients #1, #2, #3, #4, #5, #6 and #7 along with staff CS #1, current home manager/HM #5, and Support Associates/SAs #4, #5 and #6. Client #2 was cooking dinner and supervised by SA #6. Client #1 was in his bedroom and later came out to greet the visitor and discuss a recent mishap when he injured his front two teeth. Client #1 had visible marks to his nose and left thumb area. He was redirected by staff to sit at the dining table and engage in activities (coloring). Clients and SA staff ate the evening meal of spaghetti, salad, garlic bread beverages and fruit at 5:10 PM. Client #1 sat beside SA #4 (only male staff currently employed at the facility) and continued to talk throughout</p>			

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	<p>his meal; even as he chewed his food.</p> <p>Observations were conducted at the facility on 8/27/13 from 6:30 AM until 8:50 AM and from 11:00 AM until 3:00 PM. Client #1 did not go to the workshop with clients #2, #3, #4, #5, #6 and #7 at 8:30 AM. CS #1, HM #5 and SA #8 were at the facility with client #1. HM #5 had to leave the facility at 2:00 PM; but staff #9 came to take her place. At 1:30 PM on 8/27/13, client #1 indicated to the surveyor he had needed dental restoration of his front two teeth after he had fallen in the community.</p> <p>Documents provided by the day services/DS staff #1 were reviewed on 8/27/13 at 9:30 AM. An incident report dated 5/6/13 at 1:55 PM by DS #1 indicated in part..."911 was called and the 1 [local city] policeman arrived. The policeman tried to talk [client #1] down. [Client #1] kept trying to get a computer to work. [Client #1] would not calm down. The police turned his red tazer light on and told [client #1] he did not want to use it. The policeman left the workshop area to call for a 2nd police. A second police arrived. [client #1] resisted them. The Police told [client #1] several times to put his hands behind him, he did not. A policeman put [client #1] on the floor. [Client #1] continued to fight and</p>			
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	<p>would not lay still. A policemen used the tazer on [client #1]. Completed handcuffing, talked to (sic) [client #1]. 2 county sheriff (sic) deputies arrived, they talked to [client #1] as he sat on a chair. [Client #1] told them he had been tazed before. EMT's (sic) (Emergency Medical Technicians) arrived and checked [client #1]. The police took custody of [client #1]. We gave them medical information. [CS #1]...said she would follow them to the hospital."</p> <p>Review of client #1's record on 8/27/13 at 11:00 AM indicated he had made short visits to the facility since 9/2012 and had been formally admitted to the facility on 4/10/13. A letter dated 4/27/13 from the day program provider indicated client #1 would commence attendance on 5/1/13. The record review also indicated an Interdisciplinary team (IDT) meeting was held on 5/10/13 and client #1's workshop services were terminated.</p> <p>An Interdisciplinary team meeting (IDT) was held with Workshop Director/WSD #2, workshop Operations Manager/WSOM #1, the facility's Clinical Supervisor/CS #1, workshop/WS staff #5, Bureau of Developmental Disabilities Services representative (via phone) BDDS #1, and client #1's guardian. The IDT discussed the client #1's 5/1/13 and</p>						

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	<p>5/6/13 behavioral incidents. It was determined the client could not be served in a typical community group home setting and required an Extensive Support Needs/ESN placement. "The team has mention (sic) that [client #1] needs a more secure placement they are afraid of what [client #1] will do the next time since he did attack a lady when he went AWOL/Absent Without Leave (eloped). BDDS said needs to put [client #1] on list for ESN home." Workshop representatives indicated client #1 could not be served at the workshop. "BDDS want to go (sic) forward with getting level of care started to move [client #1] to a ESN home. [Client #1's] guardian agrees to move [client #1]. W/shop (workshop staff) team member agrees to move for his (client #1's) protection and to protect the community as well."</p> <p>Interview with WS #1 and Work Services Director #2 on 8/27/13 at 10:08 AM indicated their workshop building also accommodated a preschool class of eight 3 to 5 year old special needs children during the academic school year. The staff indicated client #1 remained on a type of permanent suspension and cited the presence of vulnerable children as a contributing factor to his continued absence. Work Services Director #2 expressed his concern for client #1's</p>						

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	<p>special needs in the areas of inappropriate sexual behavior (threatening rape of women) the need for structure, supervision and behavior modification. The interview indicated the present residential placement and day program currently available could not meet client #1's individual needs. Work shop Director #2 stated: "The system is letting this young man down and exposing the community to a hazard. [Client #1] needs a more intensive level of care."</p> <p>The former OM #2 did not attend the IDT of 5/10/13 concerning client #1's need for a more structured residential setting. OM #2 was the QIDP/Qualified Intellectual Disabilities Professional responsible for supporting active treatment efforts on behalf of the residential staff and CS #1 as well as clients #1, #2, #3, #4, #5, #6 and #7.</p> <p>III. Review of facility incident reports and Bureau of Developmental Disabilities Services/BDDS reports on 8/27/13 at 9:30 AM and at 2:15 PM and on 8/28/13 at 12:00 PM indicated the following:</p> <p>A BDDS report dated 6/7/13 with incident date of 6/7/13 at 7:15 AM indicated client #1 eloped from the facility after it was discovered he had stolen iPad out of staff's purse. Client #1</p>			

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	<p>was sitting on his bed with the iPad underneath him. Staff retrieved the iPad. Client #1 ran out of the house but "staff could not keep up with him. Staff got in the van to follow him but he was out of sight. Staff found him at the intersection about a mile from the home. He was out of eyesight of staff for about 10 minutes. At the intersection he was standing in the road staff parked the van, called the police and proceeded to attempt to get him in the van. Police arrived restrained him on the ground and placed him in handcuffs to ensure his safety. Police told staff they had also received a call from a lady that reported [client #1] had accosted her in the parking lot as she was going to work." HM #5's witness statement attached to the BDDS report indicated the "lady" was a paralegal who had freed herself from client #1 and locked herself in her car.</p> <p>Confidential interview A indicated client #1 had eloped from the facility in June 2013 and sexually assaulted a local lady in the community by grabbing at her chest and telling her "I am going to rip off your clothes and rape you."</p> <p>IV. Review of facility incident reports and Bureau of Developmental Disabilities Services/BDDS reports on 8/27/13 at 9:30 AM and at 2:15 PM and on 8/28/13 at</p>						

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	<p>12:00 PM indicated the following:</p> <p>A BDDS report dated 6/27/13 with incident date of 6/27/13 at 7:45 AM indicated client #1 was sitting at the dining room table and wanted to stand up. Client #2 was looking at the posted chore chart and client #1 became upset and was cursing peers (Clients #2 and #7) and staff. Client #1 went into the kitchen and yelled and cursed and threw a plate at TL 3. Client #1 reached into a drawer obtaining a table/butter knife and threatened TL #3 with it. Staff attempted verbal redirection, but client #1 ran out the facility's backdoor. Staff pursued him in the van. Staff kept him in eyesight but were un able to convince him to put down the "butter knife" and get into the van. staff called the police for assistance. "When the police arrived [client #1] was calm and agreed he would return to the group home."</p> <p>V. Review of facility incident reports and Bureau of Developmental Disabilities Services/BDDS reports on 8/27/13 at 9:30 AM and at 2:15 PM and on 8/28/13 at 12:00 PM indicated the following:</p> <p>A BDDS report dated 7/25/13 with incident date of 7/24/13 at 5:15 PM indicated staff was assisting client #1 with cleaning his room and asked him to</p>				

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	<p>obtain some cleaning supplies to clean stains from the walls,. Client #1 became "agitated and began screaming and cursing at staff threatening to kill her. He picked up his room mate's belt and swung the buckle end at the staff; she ducked the the blow and and closed the bedroom door. [Client #1] continued screaming and striking the wall and the door with the belt buckle, stating that he would kill them all and get blood all over the walls. Staff could not intervene (sic) his behavior and called the police for assistance; police responded and requested that [client #1's] therapist be contacted. Police spoke with [client #1's] therapist and the therapist requested that the police escort [client #1] to the [name of behavioral unit]. Police complied and [client #1] was taken inpatient for observation and treatment." The internal incident (7/24/13 at 5:00 PM) report which generated the BDDS report indicated 4 facility staff were present at the time of behavioral outburst. Client #1 had been asked to get some "hot water with soap" to clean the bedroom wall. The wall His bed was beside the wall and "there was all kinds of sperm (and) spit all over the wall where his bed had been." The BDDS follow up report indicated client #1 was released from the behavioral unit on 8/2/13 and some of his behavioral medications were changed. He was to</p>			

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	<p>continue weekly therapy sessions on an outpatient basis.</p> <p>VI. Review of facility incident reports and Bureau of Developmental Disabilities Services/BDDS reports on 8/27/13 at 9:30 AM and at 2:15 PM and on 8/28/13 at 12:00 PM indicated the following:</p> <p>A BDDS report dated 8/8/13 with incident date of 8/8/13 at 9:17 AM indicated client #1 had eloped from the facility and SA #8 and HM #5 pursued him in the facility van. CS #1 observed the pursuit and followed as well. Client #1 ran through the community toward a busy state highway, fell injuring his face and teeth (was bloody) at a local gas station. The client jumped up and ran "another two blocks" west on the highway in and out of traffic without using pedestrian safety skills. The BDDS report indicated client #1 had become upset when he was asked to use soap as he washed his hands. Staff were able to "corral" him and determined he had two 2 inch lacerations (nose and chin) on his face, "several teeth in the front of his mouth appeared loose and his two front teeth were chipped in a moon shape." Facility staff took him to a local emergency room for treatment.</p> <p>During interview with client #2 on</p>						

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	<p>8/27/13 at 6:30 AM, he stated: "[Client #1] is bossy to staff. Scared of him, afraid he'll hit me. Takes CDs (compact discs) and my clothes."</p> <p>Review of client #2's record on 8/28/13 at 12:15 PM, indicated an IDT dated which indicated client #2 was client #1's room-mate. Client #2 expressed his dissatisfaction in having client #1 as a room-mate and requested a change. The IDT indicated due to the nature of the facility (two story, four bedroom dwelling with small living/dining area) client #2's request could not be accommodated.</p> <p>Team Leader staff #9, who works alone with clients during the night shift 11:00 PM to 6:00 AM, was interviewed on 8/27/13 at 6:25 AM. Staff #9 stated "[Client #1] can run like a deer, there is no stopping him" when he decides to elope.</p> <p>During a conversation with client #1 on 8/28/13 at 12:00 PM he was asked how he happened to have some marks on his nose and left thumb area and he was asked to clarify earlier statements (8/27/13 1:30 PM) regarding some dental work he had done to his front teeth. Client #1 stated "I went AWOL (absent without leave/left the facility without permission) fell [name of gas station]. (sic) Went AWOL before had behavior at [day program site] went</p>			

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	<p>to [name of town] security facility." [Client #1] (named the sheriff's deputy and spelled his surname for the surveyor) "tased me once. [The deputy] took me to [Hospital]." Client #1 was verbally redirected back to the [name of gas station] incident and the injuries to his face/teeth; he indicated he was running and fell down in the parking area of the gas station because he was not looking where he was going. When asked if he paid attention to the heavy traffic on the nearby state highway, client #1 stated he used "profanity, the 'F' word, did not look and ran toward [name] (town west of the residential facility on state highway 50, a heavily traveled road). Client #1 was reminded this highway was heavily traveled by semi-trailer trucks and assorted other vehicles and it could be dangerous for him to be running across the highway without caution as he did on 8/8/13. Client #1 stated "I'm glad they weren't drunk."</p> <p>Observations were conducted at the facility on the afternoon of 8/26/13 from 4:05 PM until 5:50 PM. Client #1, #2, #3, #4, #5, #6 and #7 along with staff CS #1, current home manager/HM #5, and Support Associates/SAs #4, #5 and #6. Client #2 was cooking dinner and supervised by SA #6. Client #1 was in his bedroom and later came out to greet</p>						

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	<p>the visitor and discuss a recent mishap when he injured his front two teeth. Client #1 had visible marks to his nose and left thumb area. He was redirected by staff to sit at the dining table and engage in activities (coloring). Clients and SA staff ate the evening meal of spaghetti, salad, garlic bread beverages and fruit at 5:10 PM. Client #1 sat beside SA #4 (only male staff currently employed at the facility) and continued to talk throughout his meal; even as he chewed his food.</p> <p>Client #1's residential placement had been identified as inadequate to meet his needs during the IDT of 5/10/13 as documented above. The LOC/level of care for an ESN placement was to be initiated by BDDS. The current house manager/HM, staff #5, and CS #1 were interviewed on 8/28/13 at 12:15 PM. The interview indicated the IDT of 5/10/13, which identified client #1's placement as inappropriate to meet his needs, was still valid. The interview indicated they had been in touch with the BDDS service coordinator to check on the status of the LOC but client #1 remained in the facility despite their best efforts to coordinate with other state agencies/BDDS. The client continued to have behavioral episodes which the residential staff were unable to control. At the time of the survey, the facility had not been able to (neglected) implement</p>						

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	<p>corrective actions to alleviate the situation and protect clients #1, #2, #3, #4, #5, #6 and #7 from psychological abuse and actual harm (client #1 sustained injuries to face/teeth on 8/8/13).</p> <p>9-3-2(a)</p>			

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W000266	<p>483.450 CLIENT BEHAVIOR & FACILITY PRACTICES The facility must ensure that specific client behavior and facility practices requirements are met.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3, and #4), and 3 additional clients (#5, #6 and #7), the facility failed to meet the Condition of Participation: Behavior Management and Facility Practices. The facility failed to ensure the rights of clients to be free of neglect, verbal, psychological and physical abuse by failing to implement strategies to address client #1's behaviors. The facility failed to ensure law enforcement was not used to deal with client #1's behaviors when behavioral management techniques failed.</p> <p>Findings include:</p> <p>Please refer to W149 for 4 of 4 sampled clients (#1, #2, #3 and #4), plus 3 additional clients (#5, #6 and #7). The facility failed to ensure the rights of the clients to be free from physical, verbal and psychological abuse by a peer by failing to implement behavioral programming effectively.</p> <p>Please refer to W285 for 1 of 4 sampled clients (#1). The facility failed to ensure behavior management techniques</p>	W000266	<p>Corrective action: The facility will train/in-service all staff at this location and Day Program designee on policies and procedures concerning client neglect and abuse, the definition of all types of abuse including verbal abuse, emotional abuse, intimidation, and psychological abuse. (ATTACHMENT A&B) The facility will train/in-service all staff at this location and Day Program designee on policies and procedures concerning client rights and protections. (ATTACHMENT B&C)The facility will train/in-service YSIS (You're Safe, I'm Safe) Physical Safety techniques, and behavior management crisis resolution to all staff at this location during orientation, and annually for recertification. (ATTACHMENT D)The facility will relocate client #1, housing him away from previous housemates, eliminating his ability to endanger either the physical, psychological, or emotional health. (ATTACHMENT E&R)This facility will make available to all residents of this group home additional counseling/ therapy as needed or requested to ensure the continued positive mental and psychological health.</p>	09/23/2013			

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	(physical escort/restraint) were employed in such a way so as to ensure the safety (prevent injury) of the client. 9-3-5(a)		(ATTACHMENT E&S)The facility will train/inserve Client rights and grievance policies to all consumers upon admission and annually. (ATTACHMENT F)The facility will obtain a Behavior Consultant for client #1. (ATTACHMENT G)A new functional assessment will be completed for client #1. (ATTACHMENT H)A new Behavior Plan for client #1 will be written, trained/Implemented for all necessary staff. (ATTACHMENT I)Client #1 will be housed elsewhere while alternate placement is located. He will not return to this group home. (ATTACHMENT E)Client #1 will be staffed 2:1 @ all times. (ATTACHMENT E)The facility will investigate all reportable incidents; any substantiated incidents will be addressed through programming goal, behavior modification goals, and necessary steps to protect the rights of all individuals. (ATTACHMENT J)Administrative Team will make appropriate recommendations for any corrective action needed. (ATTACHMENT J)Consumer's IDT will convene to discuss the outcome/recommendations from Appropriate Parties. (ATTACHMENT K)All corrective measures recommended by Appropriate Parties and reviewed and approved by IDT will be written in ISP/BSP trained and implemented. (ATTACHMENT K		

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			<p>) How we will identify others: The Clinical Supervisor will review all behavior and incident documentation weekly to identify like issues. (ATTACHMENT L)The Clinical Supervisor will review all plans to ensure all client trainings are completed. (ATTACHMENT M)Clinical Supervisor will do a functional assessment at admission and annually for each consumer to identify specific individual needs in behavior management, and ADL's/Goals. Appropriate Parties will investigate all alleged incidents per policy and procedure. (ATTACHMENT J)Appropriate Parties will make appropriate recommendations for any corrective action needed. (ATTACHMENT J)Consumer's IDT will convene to discuss the outcome/recommendations from Appropriate Parties. (ATTACHMENT K&N) Measures to be put in place:The Clinical Supervisor will ensure all staff have been trained on client's rights and protections, and have been trained on abuse and neglect. (ATTACHMENT A,B,& C) The Clinical Supervisor will review all plans to ensure all client trainings are completed. (ATTACHMENT M)Clinical Supervisor will implement/train plan addendums when an identified issue is determined. (ATTACHMENT O)The Clinical Supervisor will conduct monthly meetings and review for all staff:</p>	

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			<p>behavior documentation, incidents reportable and internal, abuse and neglect definition, ResCare policy on abuse and neglect, reporting, Client rights and protections, and review of ISP, BSP, and HRP. (ATTACHMENT P)All staff will attend an YSIS recertification training annually. (ATTACHMENT D)Clinical Supervisor will ensure all incidents are documented and reported to Appropriate Parties. (ATTACHMENT J)Appropriate Parties will follow policy and procedures for all reported incidents. (ATTACHMENT J)Consumer's will attend monthly client council meetings to discuss agency activities, grievance procedures, medical options, responsibilities, home and community safety, community activities, living options, rights, self-advocacy, and nutrition.. (ATTACHMENT Q) Monitoring of Corrective Action:Operations Manager and Program Manager will conduct Best in Class, and periodic reviews to ensure all policies and procedures are being followed.Operations Manager and Appropriate Parties will review all ISP's, BSP'S, and all addendums before training and implementation.</p>	

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W000285	<p>483.450(b)(2) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. Based on record view and interview for 1 of 4 sampled clients (#1), the facility failed to ensure behavior management techniques (physical escort/restraint) were employed in such a way so as to ensure the safety (prevent injury) of the client.</p> <p>Findings include:</p> <p>Review of facility incident reports and Bureau of Developmental Disabilities Services/BDDS reports on 8/27/13 at 9:30 AM and at 2:15 PM and on 8/28/13 at 12:00 PM indicated the following:</p> <p>A BDDS report dated 5/2/13 indicated an incident on 5/1/13 at 8:30 PM wherein client #1 became upset about the fruit salad that was served as the evening snack.</p> <p>Client #1 complained there were nuts in the fruit salad but there were not. Reasoning/redirection failed and client #1 threatened staff with a knife. The incident report by staff #4 indicated client #1 "started yelling at clients" (clients #2, #4, #5, #6 and #7). He chased staff #13 out</p>	W000285	<p>Corrective action: The facility will train/in-service all staff at this location and Day Program designee on policies and procedures concerning client neglect and abuse, the definition of all types of abuse including verbal abuse, emotional abuse, intimidation, and psychological abuse. (ATTACHMENT A&B)</p> <p>The facility will train/in-service all staff at this location and Day Program designee on policies and procedures concerning client rights and protections. (ATTACHMENT B&C)</p> <p>The facility will train/in-service YSIS (You're Safe, I'm Safe) Physical Safety techniques, and behavior management crisis resolution to all staff at this location during orientation, and annually for recertification. (ATTACHMENT D)</p> <p>The facility will relocate client #1, housing him away from previous housemates, eliminating his ability to endanger either the physical, psychological, or emotional health. (ATTACHMENT E&R)</p> <p>This facility will make available to all residents of this group home additional counseling/ therapy as needed or requested to ensure</p>	09/23/2013			

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	<p>the back door (wielding the knife). The police were called (by the neighbors) and offered assistance but were told things were calm and under control. When the police car pulled away, client #1 struck former house manager #12 in the back and face. Client #1's behaviors required two physical restraints; one lasting 2 1/2 minutes and the second lasting 3 minutes. The BDDS report indicated client #1 had sustained "some minor injuries from the behavioral outburst."</p> <p>Former house manager #12 (male staff) had been called by facility staff when client #1's behavior became unmanageable and he (client #1) chased staff #13 out of the facility with a knife. Staff #12 arrived at the facility (from his home/he was off duty) and along with male staff SA #4 attempted to escort client #1 back into the facility to protect him and the other clients from harm. The two male staff #12 and #4 employed YSIS behavior techniques with client #1 who continued to be combative with staff. Client #1 had punched staff #12 in the eye and had gotten a potato peeler (all knives had been locked up) and stabbed staff #12 in the back with it.</p> <p>A 5/2/13 time unknown nursing note by LPN #1 was attached to the BDDS report indicated the "minor injuries." LPN #1 assessed client #1 and</p>		<p>the continued positive mental and psychological health. (ATTACHMENT E&S)The facility will train/in-service Client rights and grievance policies to all consumers upon admission and annually. (ATTACHMENT F)The facility will obtain a Behavior Consultant for client #1. (ATTACHMENT G)A new functional assessment will be completed for client #1. (ATTACHMENT H)A new Behavior Plan for client #1 will be written, trained/implemented for all necessary staff. (ATTACHMENT I)Client #1 will be housed elsewhere while alternate placement is located. He will not return to this group home. (ATTACHMENT E)Client #1 will be staffed 2:1 @ all times. (ATTACHMENT E)The facility will investigate all reportable incidents; any substantiated incidents will be addressed through programming goal, behavior modification goals, and necessary steps to protect the rights of all individuals. (ATTACHMENT J)Administrative Team will make appropriate recommendations for any corrective action needed. (ATTACHMENT J)Consumer's IDT will convene to discuss the outcome/recommendations from Appropriate Parties. (ATTACHMENT K)All corrective measures recommended by Appropriate Parties and reviewed and approved by IDT will be</p>				

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	<p>documented he had "on (left) outside forearm 1 inch scratch. Various red scratch marks on mid (middle) back ranges from approx (approximately) 1/2 inch - 1/12/ in (inch) - (7 red marks noted) (Left) shoulder (lower) back of arm pit approx 1 1/2 in noted scratched area [not] open (right) shoulder - petichaie (sic) (petechaie: small round reddish spots appearing in clusters like a rash caused by bleeding under the skin/minor blood vessel injuries) noted on top of shoulder. face red (with) petichaie (sic) noted over all of client's face as well. Both eyes appear slightly swollen (with)...petichaie on upper eye lids (and) below eyes. Noted darkness under both eyes. Noted an approx. 2 1/2 in scratch on (right) side of nose. Noted petichaie (sic) on bil (bilateral) side of neck on front of neck (and) behind bil ears to hairline - Noted 2 old scars on (right lower) under arm from old bandages from previous placement."</p> <p>An unsigned investigation conducted by facility administrative staff (unknown) was initiated/dated 5/2/13 at 7:15 PM. This document was reviewed 8/28/13 at 8:00 PM. The investigation was initiated to ascertain the facts surrounding client #1's behavioral outburst of 5/1/13 and how he may have received the "minor" injuries as documented by LPN #1. The investigative report's "Summary of</p>		<p>written in ISP/BSP trained and implemented. (ATTACHMENT K) How we will identify others: The Clinical Supervisor will review all behavior and incident documentation weekly to identify like issues. (ATTACHMENT L)The Clinical Supervisor will review all plans to ensure all client trainings are completed. (ATTACHMENT M)Clinical Supervisor will do a functional assessment at admission and annually for each consumer to identify specific individual needs in behavior management, and ADL's/Goals. Appropriate Parties will investigate all alleged incidents per policy and procedure. (ATTACHMENT J)Appropriate Parties will make appropriate recommendations for any corrective action needed. (ATTACHMENT J)Consumer's IDT will convene to discuss the outcome/recommendations from Appropriate Parties. (ATTACHMENT K&N) Measures to be put in place:The Clinical Supervisor will ensure all staff have been trained on client's rights and protections, and have been trained on abuse and neglect. (ATTACHMENT A,B,& C) The Clinical Supervisor will review all plans to ensure all client trainings are completed. (ATTACHMENT M)Clinical Supervisor will implement/train plan addendums when an identified issue is determined. (ATTACHMENT O)The Clinical</p>				

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	<p>evidence" component indicated:</p> <p>"Witness statements and documents relevant to the investigation were collected and reviewed.</p> <p>Review of [client #1's] BSP (Behavior Support Plan) indicates that restrictive strategies when [client #1] engages in physical aggression are to go to 1:1 staff (one staff assigned to the client) at first sign of being upset, take him for a walk, encourage him to call family or friend to discuss what is upsetting him, and to use Advanced YSIS (You're Safe I'm Safe/agency approved and taught behavior management techniques) if he is showing signs of harm to himself or others. review of his BSP further indicates that if [client #1] exhibits SIB (Self Injurious Behavior) staff will use YSIS if needed...Review of nurse's assessment reveals the presence of numerous scratches and areas of 'rug burn' over [client #1's] face and shoulders.</p> <p>Witness statements reveal that while staff did not implement YSIS as trained, they did not contribute to the minor injuries sustained in this incident."</p> <p>The investigation's "Conclusion and Findings" component indicated: After review of all statements and information collected, it is the consensus of the investigation committee (persons unknown) that there was no violation of</p>				<p>Supervisor will conduct monthly meetings and review for all staff: behavior documentation, incidents reportable and internal, abuse and neglect definition, ResCare policy on abuse and neglect, reporting, Client rights and protections, and review of ISP, BSP, and HRP. (ATTACHMENT P)All staff will attend an YSIS recertification training annually. (ATTACHMENT D)Clinical Supervisor will ensure all incidents are documented and reported to Appropriate Parties. (ATTACHMENT J)Appropriate Parties will follow policy and procedures for all reported incidents. (ATTACHMENT J)Consumer's will attend monthly client council meetings to discuss agency activities, grievance procedures, medical options, responsibilities, home and community safety, community activities, living options, rights, self-advocacy, and nutrition.. (ATTACHMENT Q) Monitoring of Corrective Action:Operations Manager and Program Manager will conduct Best in Class, and periodic reviews to ensure all policies and procedures are being followed.Operations Manager and Appropriate Parties will review all ISP's, BSP'S, and all addendums before training and implementation.</p>		

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	<p>ResCare Policy. It is further determined that YSIS was not implemented in accordance with the training provided."</p> <p>Interview with workshop supervisory/WS staff #1 on 8/26/13 at 3:30 PM indicated client #1's former house manager/HM staff #12 had been to the workshop to pickup clients (date unknown) and workshop staff had noticed a blackened eye. When asked about his black eye, HM #12 indicated client #1 had hit him and he showed workshop staff an injury said to be caused by being attacked with a potato peeler by client #1 during the same behavioral outburst (5/1/13 8:30 PM).</p> <p>9-3-5(a)</p>				