

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G309	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/11/2013
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NAME OF PROVIDER OR SUPPLIER REHABILITATION CENTER DEVELOPMENTAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 2107 E POWELL AVE EVANSVILLE, IN 47714
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 10/3, 10/4, 10/8, 10/9 and 10/11/13</p> <p>Facility Number: 000828 Provider Number: 15G309 AIMS Number: 100239660</p> <p>Surveyor: Paula Chika, QIDP-TC</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed October 22, 2013 by Dotty Walton, 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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W000120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client. Based on interview and record review for 1 of 3 sampled clients (#2), the facility failed to ensure the outside service/school utilized an appropriate restraint which did not cause injury to a client. The facility failed to ensure the outside services/school added an approved restraint technique to the client's behavior plan as recommended from the investigation of the injury due to a school restraint.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 10/3/13 at 1:14 PM. The facility's 2/7/13 reportable incident report indicated "On 2-7-2013, around 12:00 pm, the group home coordinator received a call from [name of high school] stating that [client #2] was having a behavior in the cafeteria and that we would need to come and pick him up right away. We were told that he was trying to take something from someone else in the cafeteria, and when they told him no and tried to keep him in the booth he began grabbing, hitting, and spitting at others. The group home coordinator called the manager and the</p>	W000120	Preventatively, there are many systems in place to ensure the group home and the school system maintain consistent strong communication. Quarterly IDT meetings are held at the school in order to allow current issues surrounding programming, behaviors, etc. to be discussed in detail. Also, anytime a behavioral issue arises that requires intervention, the school system notifies the group home immediately with the details of the situation. This immediate communication allows IDT the opportunity to review the situation, make suggestions, ask additional questions, and/or schedule a meeting for further discussion if necessary. The group home manager and group home coordinator also visit the school on a routine basis for observation purposes. We have found routine observations and communication with the school personnel often ensures proactive interventions are occurring which prevents behavioral issues from occurring altogether. Lastly, the EVSC Special Education Administration was notified of our concerns related to this situation, which prompted an investigation on their part, and the institution of the Safe Crisis Management	11/11/2013			

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	<p>manager immediately went to get [client #2]. When the manager arrived at [name of high school], [client #2] was not in his classroom, so she walked down to the cafeteria. At that time, it was observed that [client #2] was being restrained in a booth by three men (assistant principal, school teacher interim, and a security guard). Each of his arms were being held out straight at his sides (one person on each side) and then one person was pushing him forward so his upper body was bent over the booth table. The manager approached and said [client #2's] name, he looked up at her and by his eyes, she knew that he was calm. She asked them to please release him and that she would be able to handle him from there. [Client #2] immediately took the manager's hand and was ready to leave. [Client #2] rode home with the manager with no further issue. [Client #2] was checked and found to have some marks on his upper left arm where his arm was being held, and he also had several markings on his stomach and sides from where he was bent over the table. It is anticipated that the reddened areas may progress into bruising as the areas heal. Administration immediately began an investigation into the situation. [Client #2] is being held from school until a meeting can be conducted with school personnel, as well as with Special</p>		<p>technique. The Special Education Administration also participates in intermittent IDT meetings and observes while in the schools to ensure appropriate interventions are occurring with all clients. All of these checks and balances ensure appropriate programming and interventions are occurring on routine basis. Systemically, the Residential Coordinator will participate in the quarterly IDT process and will also be involved in the intermittent communication and IDT process if any situation would arise requiring SCM intervention. The Residential Coordinator was retrained as a result of this oversight related to the SCM not being placed in the school plan after it was agreed upon. Therefore, the retraining of the Residential Coordinator will ensure follow through related to documentation occurs in a timely manner. The Residential Coordinator will request documentation on all changes, and if it is not received timely, will follow up until documentation is received. The preventative measures listed above will ensure the documented programming changes occur on a routine basis.</p>				

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	<p>Education Services. [Name of school] administration was contacted to get the details of the situation and they explained that the safety of the other students was compromised so the restraint was necessary to ensure others (sic) safety. We explained that we are concerned with the restraint as he did incur injury and the meeting would be necessary before [client #2] can return in order to develop a futuristic plan of action that would not result in him being restrained and injured. [Name of school corporation] Special Education was also contacted at 8 am on 2-8-2013, and they are conducting their own internal investigation into the situation and will contact us to set up a meeting to discuss and develop future plan of action."</p> <p>The facility's 2/14/13 follow-up report indicated "The school has recently implemented Safe Crisis Management (SCM). [Client #2's] teacher and the Assistant Principal have both been trained in SCM. [Client #2's] IEP (Individual Education Plan) was discussed, and safe crisis management has been implemented into his behavior section of the IEP. Our BC (Behavior Clinician) will ensure the teacher and school personnel implement the behavior plan as it was discussed thoroughly in this meeting...."</p>						

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	<p>Client #2's school record was reviewed on 10/9/13 at 9:10 AM. Client #2's 8/6/13 Functional Behavioral Assessment (FBA) indicated client #2 demonstrated physical aggression (hitting, spitting, kicking and grabbing clothing) as a "...result of seeing/remembering/being kept from drinks and/or their containers. These typically happened before or during gym, in the cafeteria, or in the vocational area where refrigerators are present. Other times we have seen similar incidents are when [client #2] is kept from 'fixing' something in his environment, directly related to his obsessive-compulsive behaviors...."</p> <p>Client #2's 8/6/13 school Behavior Intervention Plan (BIP) indicated client #2 was given the opportunity to have drinks every 30 minutes. Client #2's BIP indicated "...If unwanted behavior of grabbing clothing or body parts of a staff member, or spitting occur, try and diffuse the situation alone before multiple staff members are assisting. Reduce the amount of communication between yourself and [client #2]. One person, in a monotone voice should tell him that it is okay and to calm down. Remove other students and staff away from the location of the altercation to decrease attention and anxiety levels. It has been helpful in the past to redirect him to another job ('soft'</p>						

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	<p>activities) or locations (Bathroom) to divert his attention from possible triggers or antecedents of the behavior. If the behaviors become too intense, call (administrative staff #4) (phone number) or the emergency pager to make them aware of the situation. At that time, A group home staff member will come to the school and try and help diffuse the situation. [Client #2] will be sent home from school by calling the emergency pager (phone number) if deemed necessary by his teacher of record or member, group home staff member, or school administration." Client #2's 8/6/13 BIP did not indicate the school incorporated the use or an approved restraint technique into client #2's 2/12/13 IEP and/or 8/16/13 BIP as indicated by the 2/14/13 follow-up report from the 2/12/13 meeting with the school.</p> <p>Interview with the Teacher #1 10/9/13 at 9:13 AM indicated she was not present the day client #2 had to be restrained. Teacher #1 stated client #2 was doing "A lot better this year. Going a full day." Teacher #1 indicated she had been trained in regard to SCM. Teacher #1 indicated the SCM had not been incorporated into client #2's BIP. The teacher indicated the SCM would be implemented into the client's BIP next week.</p>						

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	<p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) and staff #1 on 10/9/13 at 9:35 AM indicated they were concerned how the school had restrained client #2 at the school. Staff #1 stated the security guard/police officer, teacher and the Assistant Principal had the client's chest/abdomen "pushed up against the table." Staff #1 stated 2 school staff had the client's arms extended out with the third school staff person, at client #2's back, "pushing" the back of client #2's head forward with the client bending over the table. Staff #1 indicated the restraint occurred while the client was seating in a booth table. Staff #1 and the QIDP stated client #2 should not have been restrained as client #2 had displayed his "typical behavior." QIDP #1 indicated client #2's teacher was absent from the school that day and a substitute teacher was present who did not know how to handle client #2. QIDP #1 and staff #1 indicated client #2 was kept home from school until a meeting was conducted with the school. QIDP #1 indicated the use of the SCM was to be incorporated into the client's IEP. QIDP #1 and staff #1 indicated Mandt (restraint techniques) was a part of client #2's behavior plan at the group home.</p> <p>9-3-1(a)</p>			

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W000240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on interview and record review for 1 of 3 sampled clients (#2), the client's Individual Support Plan (ISP) and/or behavior plan did not indicate how facility staff were to monitor the client when in the community to prevent the client from obtaining/ingesting cigarette butts.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, Behavior Incident Reports (BIRs) and/or investigations were reviewed on 10/3/13 at 1:14 PM. The facility's BIRs indicated the following:</p> <p>-9/5/13 "[Client #2] was walking to the bus with staff and other residents when he spotted a cigarette butt in the driveway. Staff attempted to redirect [client #2] onto the bus but he grabbed it and put it in his mouth..."</p> <p>-8/28/13 "...While walking to the bus (sic) [client #2] saw a cigarette butt so he reached down and inserted butt into his mouth...."</p> <p>-7/15/13 Client #2 went on a doctor's appointment in the community. The BIR indicated when the doctor's appointment was over, "[Client #2] was getting into staff's car when spotted a cigarette butt on ground and ate the butt." The BIR indicated facility staff attempted to hide the cigarette butt with their foot while redirecting client #2 into the car. The BIR indicated once they got into the car, client #2 jumped out of the car before staff could engage the power locks, retrieved the butt from the street and ingested it.</p>	W000240	Immediately after the citation on 10/11/13, administration met. The behavior strategy that was actively being run was formalized into the behavior strategy. The citation at W240 indicated that the behavior strategy did not specifically indicate how staff were to handle client#2 while out in the community. IDT met and specifically added the "while out in the community" portion of the behavior strategy within the plan of correction. Observations were to be made once per week for 4 weeks. The appropriate personnel were retrained regarding ensuring behavior programming is formalized on the behavior strategy as needed. Additionally, a behavior discussion section was implemented on the weekly administration meeting agenda as an additional check and balance. On 11/4/13, the plan of correction for W240 was not approved. A more frequent mandatory monitoring system and on-going monitoring systems were asked to be added. On 11/11/13, an addition to the plan of correction was sent to address those concerns. The observations were increased to 3 times per week. The system was upgraded to have the group home	11/11/2013			

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	<p>Client #2's record was reviewed on 10/8/13 at 1:08 PM. Client #2's 9/5/13 IDT (interdisciplinary team) Record indicated "IDT met as [client #2] ingested a cigarette butt prior to getting on the school bus. IDT agreed to have staff go look for cigarette butts, drinks etc. prior to the bus coming at 7:00 AM. Staff will also be retrained on how to walk [client #2] to the bus to prevent him from getting inedibles."</p> <p>Client #2's 7/2/13 Behavior Strategy indicated client #2 demonstrated the behavior of attempting to eat in-edibles which was part of the client's Obsessive Compulsive Disorder/behavior. Client #2's 7/2/13 behavior plan indicated "...4. [Client #2] will be monitored closely to ensure that he does not place in-edible items in his mouth and/or ingest them..." Client #2's 7/2/13 behavior plan, ISP and/or 9/5/13 IDT note did not specifically indicate how facility staff were to monitor the client when out in the community for appointments/activities to prevent the client from eating cigarette butts/in-edible objects/items.</p> <p>Interview with Qualified Intellectual Disabilities Professional (QIDP) #1 and staff #1 on 10/9/13 at 9:35 AM indicated client #2 would consume cigarette butts. QIDP #1 and staff #1 indicated facility staff had been inserviced on how to handle client #2 when he was out in the community. QIDP #1 and staff #1 indicated client #2's ISP and/or behavior plan did not specifically indicate how facility staff were to handle client #2 while out in the community for doctor's appointments and/or activities in the community.</p> <p>9-3-4(a)</p>		<p>manager observe behavior issues multiple times weekly and the Residential Coordinator attend all IDT's to ensure behavior programs are effective and formalized as needed. On 11/13/13, W240 was deemed inadequate again. The request was for a system and behavior plan to prevent the client from ingesting cigarette butts. As a result, a copy of this portion of client #2's behavior strategy will be included. *See attached documents As evidenced by the behavior data, this behavior strategy has been effective. The behavior program is effective in preventing client #2 from eating cigarette butts. Systematically, we have added several steps: · Retrain Residential Coordinator on her role to ensure that behavior plans are formalized into a written strategy. · A "client's behavior" section will be included into the weekly administration meeting with the Residential Coordinators to add an additional check and balance. · Group Home Manager will observe at least 3 days per week to ensure written behavior plans are in place and followed, including all programming. · Residential Coordinators will begin attending all IDT's to review and discuss behavioral issues and programs. In addition to these items, the administrator will begin random checks of behavior strategies for thoroughness and</p>				

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			inclusion of all settings. Additionally, Human Rights Committee will be refocused on ensuring all reviewed behavior programs include all settings. In general, assessment and program writings are effective. However, in the event that an error may occur, there are multiple systems checks now in place. All of these items in place supplement the check and balance system to ensure that strategies that are in place and effective are also always formalized on the written strategy.	

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W000263	<p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on interview and record review for 1 of 2 sampled clients (#2) with restrictive programs, the facility failed to obtain written informed consent from the client and/or the client's mother (Healthcare Representative) in regard to the client's restrictive program (behavior plan/medications).</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 10/8/13 at 1:08 PM. Client #2's 9/26/13 physician's orders indicated client #2 received Risperdal 4 milligrams two times a day, Depakote 125 milligrams 6 capsules two times a day, Clonidine HCL 0.2 tablets three times a day and Prozac 20 milligrams 3 times a day for behaviors/Obsessive Compulsive Disorder.</p> <p>Client #2's 7/2/13 Behavior Strategy indicated client #2 demonstrated physical aggression (hits, grabs, pushes and etc...). Client #2's behavior plan indicated "#3...If he does not appear to be calming down, tell him that you will give him 5 minutes</p>	W000263	RCDS practices have been followed to get written informed consent from client #2's parent regarding his 7/2/2013 behavior strategy. The behavior strategy has been mailed for approval on three different occasions. The RCDS Office Coordinator has an effective system in place to obtain written informed consent; however, some parent/guardians are not prompt in returning paperwork. The RCDS Office Coordinator will continue to work diligently to obtain written informed consent on client #2's behavior strategy.	11/08/2013			

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	<p>to relax. Staff should remain outside of [client #2's] bedroom door until he is calm listening to ensure that he is safe. 4. Staff should visually check on [client #2] every 5 minutes. Once he has been calm for 5-10 minutes, he should be redirected back to the current activities. 5. If becomes physically aggressive to the point that he is endangering himself or others, staff should place [client #2] in the appropriate Mandt (physical restraint) hold. The hold will be released after [client #2] appears to have calmed down or after 3 minutes. The hold must never last longer than 3 minutes at one time. If [client #2] drops to the floor, the hold must be released." Client #2's behavior plan indicated facility staff could utilize a one person hug, a two person side hug, a one or two person moving restraint and/or a one or two person restraint while standing.</p> <p>Client #2's 7/2/13 Individual Support Plan (ISP) indicated client #2 was his own guardian and client #2's mother was the client's Health Care Representative (HCR). Client #2's 7/2/13 ISP and/or behavior plan indicated client #2 and/or his HCR did not give written informed consent for the client's restrictive behavior plan.</p> <p>Interview with Qualified Intellectual</p>						

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	<p>Disabilities Professional (QIDP) #1 and staff #1 on 10/9/13 at 9:35 AM indicated client #2 was his own guardian but client #2's mother was the client's HCR. QIDP #1 and staff #1 indicated the client and/or his mother had not signed the restrictive program/plan.</p> <p>9-3-4(a)</p>				