STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G304	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL SERVICES SUB LLC	4812 W SR 45 BLOOMINGTON, IN47401

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W0000	This visit was for an investigation of complaint #IN00100018. Complaint #IN00100018: Substantiated. Federal/state deficiencies related to the allegation are cited at W120 and W149. Unrelated deficiencies cited. Dates of Survey: December 5, 6, 7 and 8, 2011. Facility number: 000823 Provider number: 15G304 AIM number: 100249090 Surveyor: Steven Schwing, Medical Surveyor III These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/16/11 by Ruth Shackelford, Medical Surveyor III.	W0000		
W0104	The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview for 8 of 8 clients living in the group home (A, B, C, D, E, F, G and H), the governing	W0104	The staff in the home were trained on completing work orders for the home timely on	12/30/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	body failed to implement its policies and procedures to ensure a hole in the wall in the staircase was repaired timely. Findings include: An observation was conducted at the group home on 12/5/11 from 4:02 PM to 5:00 PM. During the observation, a hole was noted in the wall of the staircase leading from the basement to the first floor of the home. The hole was 7 inches by 5 inches. A review of the facility's incident reports was conducted on 12/5/11 at 2:50 PM. The Bureau of Developmental Disabilities Services (BDDS) report, dated 11/23/11, indicated on 11/22/11 at 7:45 PM, client E attempted to grab medications out of a med bin staff was carrying into the med room. Staff #7 restrained client E. The report indicated client E had punched a hole in the group home wall. An interview with the Program Director (PD) was conducted on 12/6/11 at 1:21 PM. The PD indicated client E caused the hole in the wall during a behavior. The PD indicated a work order was not submitted to repair the hole. An interview with the maintenance staff was conducted on 12/7/11 at 12:45 PM.		12/12/2011.Responsible Party: Staff, Home Manager, Program Director	

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	The maintenance staff indicated he was not informed of the hole in the stairwell until 12/5/11. An interview with the Area Director (AD) was conducted on 12/6/11 at 12:59 PM. The AD indicated he was not aware of the hole in the wall until 12/5/11 when he was at the home. The AD indicated he spoke to maintenance on 12/5/11 and maintenance had not been notified of the hole. The AD indicated the hole needed to be repaired. 9-3-1(a)			
W0120	The facility must assure that outside services meet the needs of each client. Based on record review and interview for 1 of 6 clients who attended an outside services program (C), the facility failed to ensure the program met the needs of the client. Findings include: A review of the facility's incident/investigative reports was conducted on 12/5/11 at 2:50 PM. -On 11/15/11 at 12:00 PM, client C had just finished smoking while at the day program. Client C was told his residential	W0120	Client C's IDT met on 12/21/2011 to discuss his Behavior Development Program and to develop a plan for implementation of ongoing changes to his plan and any other client's plan who is served by the day program.For any client with a new plan or changes to their plan, the plan will be implemented only after the day program has received a hard copy of the plan and documented training has occurred.Re-training with the Home Manager and Program Director on completion of observations at the day programs was completed on 12/28/2011.The Area Director will	12/30/2011

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	staff arrived and was ready to take him to an appointment. Client C informed his staff that he wasn't going to his appointment and the staff told him that it had been canceled. At this point client C grabbed the staff by the neck with both hands. The day program staff followed client C's behavior plan by trying to get him to calm down and release his hold on the staff's neck. Instead of releasing her he grabbed her hair and started pull it while keeping her in a neck hold. When he did not calm down, day program staff called 911 and asked for assistance. Both residential staff continued to use calm voices while asking client C to release the residential staff. The day program staff told client C that the police would be there soon and when he heard the sirens he released his hold on the staff just as the police were arriving. Client C was handcuffed with his hands in front of him. The day program Director talked with the officer explaining what had happened and client C would need to be taken to the county jail. She also talked with the Area Director (AD) and the AD agreed that client C should be taken with the officer. The officer called the AD to confirm the plan and client C was taken to the county jail where he waited for a residential staff to pick him up. -On 12/5/11 at 10:10 AM, client C was at		review all observations forms from the Home Manger and Program Director monthly to ensure completion and that outside services are meeting the needs of the clients.Responsible Party: Home Manger, Program Director, Area Director	

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	the day program. Prior to the incident, client C "demanded" day program staff (DPS) #1 call his group home to pick him up early. Client C was redirected to work. Client C turned the workshop lights off and threatened to harm others if they tried to turn on the lights. DPS #1 attempted to speak to client C however client C called her a "b----" and a "dumb a--" and threatened to put her on the ground. The other clients, "approximately 30" were all silent. DPS #1 indicated the clients were afraid client C was going to hurt them. DPS #1 called the residential staff to have client C picked up. Client C was informed of this information. DPS #1 informed 2 male staff to keep client C within line of sight to ensure the safety of the other clients. Client C got into the staff's desk to get a key to unlock his cigarettes. Staff attempted to redirect but client C ignored the staff. Client C then gave the key back to staff. Client C went outside to smoke. Client C saw DPS #1 outside and told her he was "p-----" at her. Client C told the staff, "I'm gonna put your m----- f------ a-- on the ground" and "I'm gonna punch you in the g------ face." The staff entered the building using a key pad so client C could not follow her. Client C went into the building using another entrance. Client C approached DPS #2 and threatened her. DPS #2 stood up and when client C got close enough to			

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	her, he put his hand in her face and threatened her. Client C grabbed DPS #2 by the coat with one hand and drew back his fist with the other. DPS #3 blocked client C's punch. Client C grabbed DPS #2's throat and chest leaving several scratches. DPS #1 arrived back to the area and called 911 due to client C not releasing his grip on DPS #2. Client C released DPS #2 about 5 minutes later. The residential staff arrived at this point and went outside with client C to wait for the police. Client C told the police he knew what he did was wrong. The police were informed DPS #2 wanted to press charges against client C. Client C was arrested for aggressive battery and client C was handcuffed and taken to jail. A review of client C's Client Conference Summary, dated 11/17/11, was conducted on 12/6/11 at 12:29 PM. The summary indicated client C would get a cigarette when he arrived at 8:00 AM with the expectation client C would follow the day program schedule. The summary indicated, "Staff will NOT give [client C] a cigarette until break time." Staff would offer sugar-free hard candy when he wanted a cigarette. There was no documentation the staff at client C's day program received training on the plan. A review of client C's Individual			

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	Habilitation Plan, dated 11/17/11, was conducted on 12/7/11 at 10:45 AM. The plan indicated it was a Special Review. The plan indicated client C would receive 25 cigarettes per week at the day program, 5 for each day. He would receive 1 at 8:00 AM, 2 at break, and 2 at noon. There was no documentation staff at the day program received training on the plan. A review of client C's Behavior Development Plan (BDP), dated 6/30/11, was reviewed on 12/7/11 at 3:07 PM. The BDP indicated client C had a targeted behavior of physical assault (PA), bossing, verbal abuse (VA) and intimidation to gain cigarettes. PA was defined as, "*Physical Assault* - Attempted or actual purposeful attacks directed at other people that may include striking, kicking, pulling hair, violently pulling clothing or glasses, biting or throwing objects." Bossing was defined as, "*Bossing* - Acts of telling other consumers or staff members what tasks to complete or not complete. Also, telling others that what they are doing is wrong." Verbal abuse was defined as, "V*erbal Abuse* - Threats, mocking or derisive language directed at others that is outside the context of a joke or banter." Intimidation to gain cigarettes was defined as, "*Intimidation to Gain Cigarettes* - Threatening, or being forceful with others			

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	in order to be given cigarettes." The mood stability training (MST) section of the BDP indicated the following, "When client C begins to show signs of anger (extreme irritability, temper outburst), refer to the "How to Relax" list, approach client C, name the activities on the list, and ask him if he would like to participate in one of them. Remind client C about using problem solving to address his issue (see component 3). 2. If he is working on a required activity, suggest that she take a break (tell him about how long the break should be) to engage in the relaxing activity and then return. 3a. If client C immediately agrees to use MST and starts the activity provide brief encouragement and then leave his vicinity. 3b. If client C does not agree to use MST or if he agrees and then resumes his angry behavior, remove others from his vicinity. 4. If client C uses MST but does not resume a required activity within a reasonable time, seek him out and prompt him to come back. 5. When client C has been calm for 15 minutes, others may interact with him again. The Responding to Targeted Problem Behaviors section indicated the following, "Physical Assault: 1. Immediately approach client C and direct him to stop the assault; use a flat unemotional tone. 2. Remove all residents and staff (yourself included) from his immediate vicinity to eliminate			

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	targets. 3. If he pursues and reinitiates physical assault, use the minimum amount of physical guidance necessary to stop the aggression; (Use the techniques taught in the agency-approved crisis intervention.) 4. Stay between client C and others and observe him. Prompt him to engage in MST. If he attempts to converse with you, ignore him. 5. When he has been calm for 15 minutes, gradually allow others into the environment. Staff and others may now interact with client C if he remains calm. Bossing: 1. Do not immediately respond directly to the bossing. Attend to the person that client C is bossing. Assure the person that he/she does not have to do what client C demands. 2. Gently tell client C that he is being bossy. Let him know that he does not have to worry about other people ' s behavior or responsibilities, only his own. 3. If client C continues to verbally object, walk away and attend to the person he was bossing. Inappropriate Social Behavior: 1. Ask client C to stop the behavior (be specific about what he is doing wrong) and act courteously. 2a. If the behavior stops, resume ongoing activity. 2b. If the behavior does not stop, walk away from client C and ignore him. 3. When client C has not displayed any TPB's for 15 minutes, others may interact with him. Verbal Abuse: 1. Tell client C to stop and attempt to redirect him to a specific task			

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	away from the person he is targeting. Do not attempt to resolve the issue or to talk to client C at this time. 2. Redirect client C to engage in MST. 3. If the verbal abuse continues, walk away from client C; and if other individuals attempt to interact with client C, redirect them to other activities. 4. When client C has been calm for 15 minutes, others may interact with him again. Gaining Cigarettes: 1. Tell client C to stop and attempt to redirect him to a specific task away from the person he is targeting. Do not attempt to resolve the issue or to talk to client C at this time. 2. Remind client C that he is out of cigarettes and will have to wait until he can buy some. 3. Tell the individual not to give client C any cigarettes. An interview was conducted with DPS #1 on 12/6/11 at 11:36 AM. DPS #1 indicated the staff at the day program had not received training on client C's behavior plan from the behaviorist. DPS #1 indicated she trained her staff on the plan after being sent the plan for review. DPS #1 indicated the staff at the day program should receive training from the behaviorist. DPS #1 indicated client C's behavior plan was confusing. DPS #1 indicated both staff and clients at the day program were afraid of client C. DPS #1 indicated client C had been sent home			

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	several times over the past few months due to his behavior. DPS #1 stated client C was supposed to attend the day program until 12:00 PM and when the staff were late picking him up, client C would get "furious." DPS #1 indicated this occurred at least 3 times per week. DPS #1 stated client C smoked "constantly" while at the day program. DPS #1 indicated a smoking schedule was implemented after the incident on 11/15/11. DPS #1 indicated she was informed the smoking plan was to be implemented immediately. Since the plan was implemented, client C, at times, gets into the staff's desks to get keys out to obtain his cigarettes. DPS #1 indicated since the plan was implemented, client C's behavior of verbal aggression increased. He demanded cigarettes from staff and other clients. DPS #1 indicated she meets monthly with the Program Director (PD) from the group home however the PD or any other group home staff did not conduct observations at the day program. An interview with the behaviorist (BC) was conducted on 12/7/11 at 1:52 PM. The BC indicated there was no documentation in the reports indicating the staff at the day program implemented client C's Behavior Development Plan as written. The BC indicated the day program did not implement the Mood			

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	Stability Training portion (proactive measures) or the Responding to Targeted Problem Behaviors portion (reactive measures) of the plan. The BC indicated client C was not offered music or drawing according to his plan. The BC indicated distracting client C could alleviate the behavior prior to it getting out of hand. The BC indicated she trained the staff at the day program in person when client C started attending the day program. She indicated this occurred on 3/7/11. An interview with the Program Director (PD) was conducted on 12/7/11 at 12:19 PM. The PD indicated she was not informed by the day program of increased verbal aggression after the implementation of the cigarette schedule. The PD indicated she met with the staff at the day program monthly and usually conducted observations at the day program every other month or at least quarterly. An interview with the Area Director (AD) was conducted on 12/7/11 at 1:17 PM. The AD indicated the day program did not implement client C's behavior plan. The AD indicated the mood stability training was not implemented. This federal tag relates to Complaint #IN00100018.			

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W0149	9-3-1(a) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 9 of 29 incident/investigative reports reviewed affecting clients B, C, D, E, F and H, the facility neglected to implement its policies and procedures to prevent abuse and neglect. Findings include: A review of the facility's incident/investigative reports was conducted on 12/5/11 at 2:50 PM. -On 6/14/11 at 7:15 AM, client D was "tormenting" client E by spraying client E with perfume. Client E asked client D to stop but client D did not stop. Client E kicked client D. No injuries were noted. -On 6/14/11 at 11:00 PM, client B put his arms around client H in order to "subdue" client H. Client H was agitated at the other housemates. When client B was redirected by staff to release client H, client B refused and continued to hold client H. After a few verbal prompts, client B released client H.	W0149	The Program Director was re-trained on investigation guidelines for incidents and timeliness of completing investigations on 12/28/2011.The Program Director received Corrective Action for failure to complete all required investigations on 12/28/2011.Responsible Party: Program Director, Area Director	12/30/2011

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	-On 6/20/11 at 6:45 PM, client E hit client H in the chest. -On 6/29/11 at 4:30 PM, client D was "instigating" and picking a fight with client E by calling him derogatory names. Client D bit client E and client E hit client D. -On 6/30/11 at 10:00 PM, client E was agitated at the home manager (HM) due to the HM giving another client attention. Client E was verbally abusive and made inappropriate sexual comments to the HM. Client E threatened client B. Client E punched the HM. The HM, staff #4 and #8 placed client E in a restraint. He was released from the restraint and went outside to cool down. Once outside, client E destroyed property and "stormed" into the house targeting the HM and swung at her. The 3 staff restrained client E. Once calm, client E was released and he went outside again. Client E went into the group home and grabbed the appointment book. Staff #8 attempted to get the book and client E smacked the glasses off of staff #8's face and scratched his face "significantly." Staff placed client E in an upright restraint. The HM called the police once client E was calm. The investigative report, dated 7/12/11, indicated the following conclusion, "The			

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	factual findings in this investigation clearly show that the staff are in need of retraining on handling crisis situations. It appears to this PD (Program Director) that the last two restraints could have easily been avoided if other techniques had been utilized for de-escalation. The initial restraint was likely necessary after [client E] 'punched' the HM, but this was the only justifiable restraint." -On 7/15/11 at 3:30 PM, client C punched client F in the stomach. -On 7/19/11 at 6:30 PM, client H was agitated after witnessing a housemate (report did not indicate who) break a light outside. Client H told staff he was angry and he was going to walk away from the group home. Client H did end up crossing the busy street (highway), staff #7 followed close behind. Client H soon crossed back over the road to the group home. Staff #7 attempted to redirect client H away from the road but client H kept getting closer and closer to the road. Staff #7 restrained client H. Staff #7 indicated the road was busy at the time and the staff felt client H's immediate safety was in danger. Staff implemented the restraint and client H fell on top of staff. The report indicated, "PD believes that this staff's use of PIA (hold/restraint) was absolutely necessary to ensure [client			

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	H's] safety, since [client H] was not willing or able to listen to staff's rationale of moving away from the busy street." -On 10/30/11 at 7:30 PM, client E reported to the HM he had taken a yellow pill with markings of V3601 (Hydrocodone). Client E reported he received the pill from a stranger he met at a haunted house. He was taken to the emergency room and received a drug test. He tested positive for opiates. The investigation, dated 11/4/11, indicated the facility was unable to determine where the pill came from. -On 11/15/11 at 8:50 PM, client C was being restrained (report did not indicate antecedents of the restraint). While client C was being restrained, client E kicked client C in the head. Client C was taken to the emergency room and a catscan was completed with no injuries noted. A review of the facility's Operating Practices - Supervised Group Living Services, dated June 2007, was conducted on 12/5/11 at 2:07 PM. The policy indicated, "Indiana MENTOR programs maintain a written list of rights, which take into account the requirements of applicable laws, regulations, and purchasing agencies. This list of rights should include, but is not limited to: e.			

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	Ensure the clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment." An interview with the Program Director (PD) was conducted on 12/7/11 at 12:19 PM. The PD indicated the facility should investigate incidents reportable to the Bureau of Developmental Disabilities Services. The PD indicated the facility should investigate abuse, neglect and exploitation. An interview with the Area Director (AD) was conducted on 12/6/11 at 12:59 PM. The AD indicated the facility considered client to client aggression as abuse. The AD indicated the facility prohibited abuse and neglect of the clients. This federal tag relates to Complaint #IN00100018. 9-3-2(a)			
W0154	The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 5 of 29 incident reports reviewed affecting clients C, D, E, F and H, the facility failed to ensure investigations	W0154	The Program Director was re-trained on investigation guidelines for incidents and timeliness of completing investigations on 12/28/2011.The	12/30/2011

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	were conducted for client to client abuse and neglect. Findings include: A review of the facility's incident/investigative reports was conducted on 12/5/11 at 2:50 PM. The following incidents of client to client abuse were not investigated by the facility: -On 6/14/11 at 7:15 AM, client D was "tormenting" client E by spraying client E with perfume. Client E asked client D to stop but client D did not stop. Client E kicked client D. -On 6/29/11 at 4:30 PM, client D was "instigating" and picking a fight with client E by calling him derogatory names. Client D bit client E and client E hit client D. -On 7/15/11 at 3:30 PM, client C punched client F in the stomach. -On 7/19/11 at 6:30 PM, client H was agitated after witnessing a housemate (report did not indicate who) break a light outside. Client H told staff he was angry and he was going to walk away from the group home. Client H did end up crossing the busy street (highway), staff #7 followed close behind. Client H soon		Program Director received Corrective Action for failure to complete all required investigations on 12/28/2011.Responsible Party: Program Director, Area Director	

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	crossed back over the road to the group home. Staff #7 attempted to redirect client H away from the road but client H kept getting closer and closer to the road. Staff #7 restrained client H. Staff #7 indicated the road was busy at the time and the staff felt client H's immediate safety was in danger. Staff implemented the restraint and client H fell on top of staff. The report indicated, "PD believes that this staff's use of PIA (hold/restraint) was absolutely necessary to ensure [client H's] safety, since [client H] was not willing or able to listen to staff's rationale of moving away from the busy street." -On 11/15/11 at 8:50 PM, client C was being restrained (report did not indicate antecedents of the restraint). While client C was being restrained, client E kicked client C in the head. Client C was taken to the emergency room and a catscan was completed with no injuries noted. An interview with direct care staff (DCS) #7 was conducted on 12/7/11 at 12/7/11 at 2:16 PM. DCS #7 indicated client H did not cross highway 45 during the incident. DCS #7 indicated he was not should why the report indicated he crossed. DCS #7 indicated he was able to restrain client #7 prior to him crossing the highway due to the danger if he did cross. DCS #7 indicated there were numerous cars			

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	passing by the home at the time of the incident. An interview with the Program Director (PD) was conducted on 12/7/11 at 2:21 PM. The PD indicated she was not sure why the report indicated client H crossed the highway on 7/19/11. She indicated the incident should have been investigated due to the use of an emergency restraint for client H and the danger he put himself in by attempting to cross the highway. She indicated the information passed from the on-call PD to her when she submitted the report could have been miscommunicated. When asked why the interview and the report were different, the PD stated, "That's why we investigate." An interview with the Area Director (AD) was conducted on 12/6/11 at 12:59 PM. The AD indicated client to client aggression was abuse. The AD indicated all incidents of abuse should be investigated. 9-3-2(a)			
W0156	The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.			

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	Based on record review and interview of 1 of 5 investigative reports reviewed affecting client E, the facility failed to ensure the investigation results were reported to the administrator in accordance with State law within 5 working days of the incident. Findings include: A review of the facility's incident/investigative reports was conducted on 12/5/11 at 2:50 PM. On 6/30/11 at 10:00 PM, client E was agitated at the home manager (HM) due to the HM giving another client attention. Client E was verbally abusive and made inappropriate sexual comments to the HM. Client E threatened client B. Client E punched the HM. The HM, staff #4 and #8 placed client E in a restraint. He was released from the restraint and went outside to cool down. Once outside, client E destroyed property and "stormed" into the house targeting the HM and swung at her. The 3 staff restrained client E. Once calm, client E was released and he went outside again. Client E went into the group home and grabbed the appointment book. Staff #8 attempted to get the book and client E smacked the glasses off of staff #8's face and scratched his face "significantly." Staff placed client E in an upright restraint. The HM	W0156	The Program Director was re-trained on investigation guidelines for incidents and timeliness of completing investigations on 12/28/2011.The Program Director received Corrective Action for failure to complete all required investigations on 12/28/2011.Responsible Party: Program Director, Area Director	12/30/2011

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	called the police once client E was calm. The investigative report, dated 7/12/11, indicated the following conclusion, "The factual findings in this investigation clearly show that the staff are in need of retraining on handling crisis situations. It appears to this PD (Program Director) that the last two restraints could have easily been avoided if other techniques had been utilized for de-escalation. The initial restraint was likely necessary after [client E] 'punched' the HM, but this was the only justifiable restraint." An interview with the Area Director (AD) was conducted on 12/6/11 at 12:59 PM. The AD indicated the results of investigations should be reported to the administrator within 5 working days. 9-3-2(a)			
W0189	The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on record review and interview for 1 of 4 clients in the sample (E), the facility failed to ensure staff received competent training on crisis intervention. Findings include:	W0189	Staff in the home were trained on preventing client to client incidents on 12/12/2011.Staff in the home were trained on maintaining client safety during incidents involving restraints or other behavioral interventions on 12/12/2011.Staff receive re-training at least annually on	12/30/2011

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	A review of the facility's incident/investigative reports was conducted on 12/5/11 at 2:50 PM. On 6/30/11 at 10:00 PM, client E was agitated at the home manager (HM) due to the HM giving another client attention. Client E was verbally abusive and made inappropriate sexual comments to the HM. Client E threatened client B. Client E punched the HM. The HM, staff #4 and #8 placed client E in a restraint. He was released from the restraint and went outside to cool down. Once outside, client E destroyed property and "stormed" into the house targeting the HM and swung at her. The 3 staff restrained client E. Once calm, client E was released and he went outside again. Client E went into the group home and grabbed the appointment book. Staff #8 attempted to get the book and client E smacked the glasses off of staff #8's face and scratched his face "significantly." Staff placed client E in an upright restraint. The HM called the police once client E was calm. The investigative report, dated 7/12/11, indicated the following conclusion, "The factual findings in this investigation clearly show that the staff are in need of retraining on handling crisis situations. It appears to this PD (Program Director) that the last two restraints could have easily been avoided if other techniques had been utilized for de-escalation. The initial		agency approved techniques for handling behavioral incidents. Staff are also trained on the Hierarchy Procedures of the least restrictive to most restrictive interventions to be used during a behavioral incident.Responsible Party: Home Manager, Program Director, Area Director	

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	restraint was likely necessary after [client E] 'punched' the HM, but this was the only justifiable restraint." An interview with the Area Director (AD) was conducted on 12/6/11 at 12:59 PM. The AD indicated the results of investigation indicated the staff needed retraining on crisis intervention. The AD indicated the restraints could have been avoided if staff took steps to avoid conflicts. The AD indicated the HM could have told client E she would meet with him after meeting with another client. The AD indicated the HM could have taken the other client to a restaurant when client E showed signs of agitation. The AD indicated the staff should not have attempted to get the appointment book away from client E. 9-3-3(a)			
W0285	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 review and interview 1 of 4 clients in the sample (C), the facility failed to ensure his safety during a restraint.	W0285	Staff in the home were trained on preventing client to client incidents on 12/12/2011.Staff in the home were trained on maintaining client safety during incidents involving restraints or	12/30/2011

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	Findings include: A review of the facility's incident/investigative reports was conducted on 12/5/11 at 2:50 PM. On 11/15/11 at 8:50 PM, client C was being restrained (report did not indicate antecedents of the restraint or the staff who implemented the restraint). While client C was being restrained, client E kicked client C in the head. Client C was taken to the emergency room and a catscan was completed with no injuries noted. An interview with the Program Director (PD) was conducted on 12/7/11 at 12:19 PM. The PD indicated the facility should ensure the safety of a client during a restraint. An interview with the Area Director (AD) was conducted on 12/6/11 at 12:59 PM. The AD indicated the facility and staff should ensure a client's safety during a restraint. 9-3-5(a)		other behavorial interventions on 12/12/2011.Responsible Party: Home Manager, Program Director, Area Director	