

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G466	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/01/2015
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NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1926 W 75TH PL INDIANAPOLIS, IN 46260
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W 0000  Bldg. 00	<p>This visit was for the investigation of complaint #IN00176248 which resulted in an Immediate Jeopardy which was not removed prior to exit.</p> <p>Complaint #IN00176248: Substantiated, federal/state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W153, W154, W157, W159, W186, W191, W227, W240, W249, and W289.</p> <p>Unrelated deficiency cited.</p> <p>Dates of Survey: 6/23, 6/24, 6/25, 6/26, 6/29, 6/30, and 7/01/2015.</p> <p>Facility Number: 000980 Provider Number: 15G466 AIMS Number: 100244620</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0102  Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, interview, and record review, the facility failed to meet</p>	W 0102	1.Please refer to W104	07/17/2015

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

TITLE

(X6) DATE

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

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	<p>the Condition of Participation: Governing Body for 3 of 3 sampled clients (clients A, B, and C). The governing body failed to provide oversight and management to ensure the Condition of Participation: Client Protections was met. The Governing Body failed to ensure the facility implemented the facility's policy and procedures to prevent abuse, neglect, and/or mistreatment of clients A, B, and C in regards to client aggression and elopement behaviors, to ensure staff levels were sufficient and the staff were competent to supervise clients according to their identified behavioral needs, and to ensure the facility reported all allegations of abuse/neglect, completed thorough investigations, and implemented effective corrective action.</p> <p>Findings include:</p> <p>1. Please refer to W104. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented written policies and procedures to prevent abuse, neglect, and/or mistreatment of clients in regards to client aggression and elopement behaviors, to ensure staffing levels were sufficient in the home, and to ensure the facility reported all allegations of</p>		2.Please refer to W122	

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	<p>abuse/neglect, completed thorough investigations, and implemented effective corrective action for 3 of 3 sampled clients (A, B, and C).</p> <p>2. Please refer to W122. The governing body failed to ensure the facility met the Condition of Participation: Client Protections. The governing body failed to ensure the facility implemented the agency's policy and procedures to ensure the system to prohibit abuse, neglect, mistreatment and/or sexual exploitation of clients was implemented for 3 of 3 sampled clients (clients A, B, and C).</p> <p>The governing body failed to ensure the facility completed thorough investigations and initiated sufficient corrective action to address client A, B, and C's elopement behaviors.</p> <p>The governing body failed to ensure the facility protected client A from elopement after a history of elopement behaviors was identified which resulted in sexual assault, substance abuse, and personal injury.</p> <p>The governing body failed to ensure the facility staff were available and competent to supervise and to implement client A, B, and C's ISP (Individual Support Plan), BSP (Behavior Support</p>			

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W 0104  Bldg. 00	<p>Plan), and Risk Plan.</p> <p>The governing body failed to ensure the facility developed further safeguards after clients A, B, and C continued their elopement behaviors.</p> <p>This federal tag relates to complaint #IN00176248.</p> <p>9-3-1(a)</p> <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, interview, and record review for 3 of 3 sampled clients (A, B, and C), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented written policies and procedures to prevent abuse, neglect, and/or mistreatment of clients in regards to client aggression and elopement behaviors, to ensure staffing levels were sufficient in the home, and to ensure the facility reported all allegations of abuse/neglect, completed thorough investigations, and implemented effective corrective action.</p> <p>Findings include:</p>	W 0104	<p>1.Please refer to W149</p> <p>2.Please refer to W153</p> <p>3.Please refer to W154</p>	07/17/2015	

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	<p>1. Please refer to W149. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented written policy and procedures of the agency's policy and procedure to prohibit abuse, neglect, mistreatment, and/or exploitation of clients A, B, and C. The governing body failed to protect client A from elopement after a history of elopement behaviors was identified which resulted in sexual assault, substance abuse, and personal injury. The governing body failed to ensure staff were available and competent to supervise and implement client A, B, and C's ISP (Individual Support Plan), BSP (Behavior Support Plan), and Risk Plan. The governing body failed to develop further safeguards and corrective measures regarding client A, B, and C's continued elopement behaviors and complete thorough investigations for 3 of 3 sampled clients (clients A, B, and C).</p> <p>2. Please refer to W153. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility reported an allegation of client to client physical aggression to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of</p>			

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	<p>Developmental Disabilities Services) per 460 IAC 9-3-1(b)(5) and to Adult Protective Services (APS) per IC 12-10-3 for 1 of 1 allegations of abuse and/or neglect reviewed for clients A and B.</p> <p>3. Please refer to W154. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility completed thorough investigations for incidents and allegations of abuse, neglect, and/or mistreatment for clients A and B for 1 of 7 BDDS (Bureau of Developmental Disabilities Services) reports reviewed from 3/2015 through 6/24/15 (for client A) and for 1 of 1 allegation not reported (for clients A and B).</p> <p>4. Please refer to W157. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility completed effective corrective action to prevent future incidents of elopement and physical aggression behaviors for 3 of 3 sampled clients (clients A, B, and C).</p> <p>This federal tag relates to complaint #IN00176248.</p> <p>9-3-1(a)</p>			

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W 0122  Bldg. 00	<p>483.420 CLIENT PROTECTIONS</p> <p>The facility must ensure that specific client protections requirements are met. Based on observation, record review, and interview, for 3 of 3 sampled clients (clients A, B, and C), the facility failed to meet the Condition of Participation: Client Protections for clients A, B, and C. The facility failed to implement its policy and procedures to ensure the system to prohibit abuse, neglect, mistreatment and/or sexual exploitation of clients was implemented.</p> <p>The facility failed to ensure completion of thorough investigations and initiate sufficient corrective action to address client A, B, and C's elopement behaviors.</p> <p>The facility failed to protect client A from elopement after a history of elopement behaviors was identified which resulted in sexual assault, substance abuse, and personal injury.</p> <p>The facility failed to ensure staff were available and competent to supervise and to implement client A, B, and C's ISP (Individual Support Plan), BSP (Behavior Support Plan), and Risk Plan.</p> <p>The facility failed to develop further safeguards after clients A, B, and C continued their elopement behaviors.</p>	W 0122	<p>1.Please refer to W149 2.Please refer to W153 3.Please refer to W154 4.Please refer to W157</p> <p>1.A 1:1 staffing protocol has been developed for Client A and will be immediately implemented upon her return to the group home for client protections. Each staff responsible for the implementation of the 1:1 protocol will be trained prior to assuming responsibility. At this point Client A has not returned to the Group home so this 1:1 protocol has not been put into place.</p> <p>Home Manager, QIDP and Area Director have met to review the current staffing schedule and identify the staffing needs of the home. It has been identified that the staffing ratio in the home will consist of a minimum of 2 staff during waking hours, so that if one consumer elopes one staff is able to follow that consumer while the other staff can stay with the remaining clients and call the Home Manager, QIDP or emergency personnel for assistance as needed. At this time, increased staffing during overnight hours has not been a determined need on an ongoing</p>	07/17/2015

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	<p>This noncompliance resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 6/17/2015. The Immediate Jeopardy was identified on 6/24/2015 at 12:55 PM. The Agency's Area Director (AD) and the Qualified Intellectual Disabilities Professional/Program Director (QIDP/PD) were notified of the Immediate Jeopardy on 6/24/2015 at 1:00pm regarding the facility's systemic failure to ensure implementation of the agency's policy and procedure to prohibit abuse, neglect, mistreatment, and/or exploitation for client A. The facility neglected to protect client A from elopement after a history of elopement behaviors was identified which resulted in sexual assault, substance abuse, and personal injury. The facility neglected to ensure staff were available and competent to supervise and implement client A's ISP, BSP, and Risk Plan. The facility failed to develop further safeguards and corrective measures regarding client A continued elopement behaviors.</p> <p>The facility submitted a 6/26/15 letter of "Plan for Removal of Immediate Jeopardy-Addendum" on 6/26/15 at 3:53 PM. The facility's plan of action indicated the following:</p>		<p>basis, however if a situation occurs where there is an identified risk of the potential for elopement based on observations or expressed needs of the consumers or outside parties, including Day Service providers, therapists, parents/guardians, etc., additional staffing will be assigned for overnight hours. Need for ongoing additional overnight staffing will be assessed by QIDP and Area Director on a daily basis.</p> <p>When the consumers are scheduled to be out of the house for community activities, additional staffing will be assigned to accompany consumers so that if any elopements are attempted one staff will be able to follow the eloping consumer and implement Behavior Plan strategies and the other staff can remain with the other consumers. Since there are two consumers remaining in the home that have identified target behaviors of elopement, each will be provided with 1:1 staffing in the community in case elopements are attempted.</p> <p>The Home Manager and QIDP will meet minimum of weekly to review the scheduled community activities and adjust the schedule accordingly to assign additional staffing to ensure all consumers health and safety needs are being met. All direct care staff have</p>	

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	<p>- "The following actions and protective measures are in place or are in process to abate the immediate jeopardy in regards to client protections for [Client A]."</p> <p>- "A 1:1 (one on one) protocol has been developed for [Client A] and will be immediately implemented upon her return to the group home for client protection. IDT (Interdisciplinary Team) will review and update ISP (Individual Support Plan), RMAP (Risk Management Plan), and Behavior Support Plan (BSP), develop alternative activities and alternative plans for behavior prevention. IDT will meet weekly for a minimum of one month once [Client A] returns to determine if any changes need to be made to any of the above stated plans and determine if any other supports need to be put into place for [Client A]. After the first month, the IDT will determine the frequency of ongoing meetings."</p> <p>- "Area Director (AD) has requested from the Behavior Specialist Supervisor to provide additional hours of Behavior Consultation to the QIDP (Qualified Intellectual Disabilities Professional) to assist with Behavior Plan development and strategies to reduce elopement behaviors."</p> <p>- "Each staff responsible for the</p>		<p>received training on necessary staffing ratios while in the group home and out on community outings. Training included that if any situation occur that these staffing ratios are not able to be met for some reason (one client elopes, a staff is late to a shift, etc.) they are to notify the Home Manager and/or QIDP immediately so that the Home Manager and/or QIDP can arrange for additional staffing support as soon as possible so that consumers health and safety needs are being met. Another group home is located nearby that can be used as an option for additional staffing support quickly in the event that a consumers elopes or staffing situation occurs that prevents the assigned staffing ratios from being implemented until the Home Manager and/or QIDP is able to secure additional staffing or get to the site themselves.</p> <p>Management observations will be completed a minimum of daily for 6 weeks to ensure that assigned staffing ratios are being provided and Behavior Support plans are being implemented as written. Identified managers that are able to complete daily observations include QIDP, Area Director, Regional Director, Quality Assurance Manager, Behavior Specialist and any other QIDP or Area Directors that have been trained on the needs of the</p>	

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	<p>implementation of the 1:1 protocol will be trained prior to assuming that responsibility."</p> <p>-"Staff will be retrained on [Client A's] Behavior Support Plan, alternative activities and protective measures that may be determined during IDT meeting. Staff training will also include providing emotional support to [Client A] as needed."</p> <p>-"Once a date is identified by [Client A's] mom/guardian for return, the IDT including the Home Manager, QIDP, Area Director, Quality Assurance manager and Program Nurse will convene to review [Client A's] current medical status and changes in medications. In addition, appointments with [Client A's] PCP and/or Gynecologist will be scheduled if needed. Per hospital discharge recommendations, the number for [name] (a) sexual assault advocacy (organization) was given to mom. Mom gave the number to QIDP and an initial call has been made for a referral. Once a date is established for [Client A] to return to the group home an appointment will be scheduled as soon as possible to provide additional emotional support to [Client A]. [Client A's] current therapist has been notified of the incident and once a date is established for [Client</p>		<p>home. Home Managers are able to complete additional observations to ensure that assigned staffing ratios are being provided and Behavior Support plans are being implemented as written but Home Manager observations will not replace daily upper management observations. Any of the above designated managers that are completing observations will complete an observation checklist that designates if appropriate staffing levels are being maintained, if Behavior plans are being implemented as written and will review that documentation is being completed. If any issues are noted, the Management observer will immediately notify the assigned homes QIDP or Area Director so that immediate corrective measures can be put into place. The Area Director or Regional Director will review all observation checklists to ensure that appropriate staffing levels are being maintained, Behavior plans are being implemented as written and will review that documentation is being completed. After the 6 weeks, a team of the QIDP, Area Director, Regional Director and Quality assurance manager will meet to review observation results and develop plan for frequency that ongoing upper management observations will occur.</p> <p>Client A, B and C Behavior plans,</p>	

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	<p>A] to return to the group home an appointment will be scheduled as soon as possible to provide additional emotional support to [Client A]."</p> <p>-"A new goal has been developed for [Client A] and will be added to her ISP for staff to: daily, upon arrival home from her day program [Client A] will talk to a staff about how her day went and how she is feeling about the day. This goal will be implemented upon [Client A's] return to the group home and her day service program in an attempt to assess if she is having feelings or concerns that might lead her to feel she would want to elope from the home."</p> <p>-"The QIDP will facilitate IDT meetings to review and update ISP, RMAP, and Behavior Development plan, develop alternative activities and alternative plans for behavior prevention for the other two consumers in the home, [clients B and C], which also have a history of elopement."</p> <p>-"All direct care staff will receive retraining on all consumers' Behavior Support plans, ISP and Risk plans. Training will focus on specifics for preventing targeted behaviors and strategies for what to do when a targeted behavior occurs. Special emphasis will be</p>		<p>Risk plans and ISP have all been updated to reflect what level of supervision above clients need while in the group home, on community outings and in the event that an elopement occurs and after a client is returned home after an elopement behavior occurs.</p> <p>QIDP will receive retraining to include ensuring that supervision levels of all consumers are identified in their individual ISP, BSP and risk plans. Training will also include ensuring that Home Manger and QIDP are meeting weekly to review the scheduled community activities and adjust the schedule accordingly to assign additional staffing to ensure all consumers health and safety needs are being met.</p> <p>The Area Director or Regional Director will review all observation checklists to ensure that appropriate staffing levels are being maintained, Behavior plans are being implemented as written and will review that documentation is being completed. After the 6 weeks, a team of the QIDP, Area Director, Regional Director and Quality assurance manager will meet to review observation results and develop plan for frequency that ongoing upper management observations will occur.</p>	

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	<p>placed on the consumers that have elopement behaviors in their plan and what should happen if a consumer threatens or attempts to elope. Staff retraining will also include ensuring that all staff are aware of what situations are required to be reported to the HM, QIDP or on call manager and the time line in which they are to be reported."</p> <p>-"Weekly house meetings with all consumers will be held for a minimum of 4 weeks to address any concerns consumers have and provide training opportunities for safe practices. After the 4 weeks the QIDP and Area Director will determine the frequency that the house meetings will continue. Ongoing, the house meetings with all consumers will occur a minimum of monthly and will continue to include training opportunities for safe practices in the community. Addendum: All clients were interviewed individually on 6/26/15 to assess if they had any questions or concerns they wanted management to look into. No concerns were brought up during these interviews. The first scheduled 'house meeting' will occur on Monday June 29th at 4:30 PM. The QIDP and Home Manager will conduct these meetings. Ongoing the weekly meetings will occur every Monday at 4:30 PM."</p>			

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	<p>-"Home Manager, QIDP and Area Director will review the staffing schedule to determine that adequate staffing are (sic) scheduled as needed in order to ensure the consumers' needs are being met. The Home Manager and QIDP will meet a minimum of weekly to review the scheduled community activities and ensure additional staffing is provided as needed to ensure all consumers' health and safety needs are being met. QIDP and Home Manager will receive retraining to include ensuring that adequate staffing is provided in the home to ensure all consumers health and safety needs are being met. Addendum: For those clients identified with an elopement risk, adequate staffing will include a minimum of 2 trained staff. This will allow one staff to provide 1:1 supervision in the event that a client elopes and a staff to provide supervision to the other clients. In the future, if clients engage in elopement behavior during sleeping hours, Indiana MENTOR will provide additional staff during sleeping hours until the IDT determines it can be removed."</p> <p>-"Addendum: In addition to the 1:1 supervision to be provided to [client A]. Staff will be scheduled as follows to meet the needs of the 2 other clients identified with elopement risk. CLIENT1 &amp;</p>			

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	<p>CLIENT2 (sic) at the group home at least 2 trained staff will be present; CLIENT1 (sic) is in the home and CLIENT2 (sic) is in the community with no other clients, 2 trained staff will be scheduled at the home and 1 trained staff to be in the community with CLIENT2; CLIENT1 (sic) is home and CLIENT2 (sic) is in the community with other clients at least 2 trained staff will be provided at the home and 2 trained staff will be provided at the community activity; CLIENT1 &amp; CLIENT2 (sic) are in the community together with no other clients each will be provided with a 1:1 staff; CLIENT1 &amp; CLIENT2 (sic) are in the community with other clients at least 2 trained staff will be provided. This will allow one staff to provide 1:1 supervision in the event that a client elopes and a staff to provide supervision to the other clients. If Client1 or Client2 (sic) elopes or threatens to elope an additional staff will be provided during the overnight hours until the IDT determines it is no longer necessary. Additionally, if at any time staff feel there is an identified risk based on their observation or the expressed needs from clients or outside parties i.e. Day Service Provider, Counselor, Parents, etc. an additional staff will be added for the overnight hours and then assess again the next day."</p>			

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	<p>- "QIDP will be retrained on review of QIDP responsibilities related to recognizing behavioral and medical patterns and ensuring effective corrective action is taken to prevent future occurrences. Training will also include ensuring that IDT's are held as soon as possible after an incident that requires immediate protective measures to be put in place. The IDT should determine if the immediate protective measures are appropriate to continue and if any changes need to be made. QIDP will update and revise ISP, RMAP, Behavior Support Plan, etc. as needed. QIDP will ensure all staff are trained on any updates to any of the above documents. QIDP retraining will also include ensuring that documentation of IDT meetings and topics discussed is completed and available in client charts for review.</p> <p>Addendum: Area Director will meet with QIDP weekly for 4 weeks to review any incidents that have occurred in the home, the effectiveness of protective measures that have been put into place and recommendations from any IDT meetings that have occurred. After the first 4 weeks, the Area Director will meet with the QIDP at least twice monthly to review any incidents that have occurred in the home, the effectiveness of protective measures that have been put into place and recommendations from</p>			

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	<p>any IDT meetings that have occurred. After 8 weeks the Area Director the frequency of ongoing meetings."</p> <p>-"Observations for the implementation of plan as prescribed by Indiana MENTOR Administrative staff will occur as follows: 5 days per week on week 1; 4 days a week on week 2; 3 days per week on week 3; 2 days per week on week 4; until we have reached 1 day observation. Assessment by the Area Director will occur at the end of each week to determine if further observations are needed. Ongoing, Home Manager and/or QIDP will complete observations routinely. Addendum: Effective 6/26/15 daily observations by Indiana MENTOR management staff will occur to provide monitoring and direction as needed to the direct support professionals. Management staff that will complete observations includes the Home Manager, QIDP, Area Director, Regional Director, Quality Assurance Specialist, and other Home Managers/QIDP's or Area Directors that have been trained on the needs of the home. Observations on work days will take place after 4:30 PM and before 9:30 PM. On weekends and /or holidays observations will take place during waking hours. After the first 7 days, observations will occur at least 6 days per week for week 2, at least 5 days per week</p>			

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	<p>for week 3, at least 4 days per week for week 4, at least 3 days per week for week 5. After week 5 and ongoing observations will occur at least 2 times per week."</p> <p>-"Area Director will review monthly all BDDS reports and complete analysis and make recommendations for trends/patterns or repeated incidents."</p> <p>Based on observation, interview and review of the facility's 6/26/15 letter of removal, it was determined the facility's plan of action had not removed the Immediate Jeopardy and the Immediate Jeopardy continued because the facility's letter of removal did not indicate how the facility was going to ensure sufficient staffing to meet the needs of clients. The Immediate Jeopardy continued because the facility needed to continue to implement its letter of compliance, development and implementation of each client's program revisions, staff re training, and to ensure sufficient staffing levels could be maintained in the group home.</p> <p>During the 6/23/15 observation period from 3:50 PM until 5:45 PM, 6/24/15 observation period from 6:30 AM until 8:10 AM, 6/25/15 observation period from 6:50 AM until 7:50 AM, 6/26/15 observation period from 6:05 AM until</p>			

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	<p>7:25 AM, 6/29/15 observation period from 4:55 PM until 5:35 PM, 6/30/15 from 12:30 PM until 12:45 PM, and 7/1/15 from 3:10 PM until 4:30 PM, client A was not present at the group home and was at her mother's home.</p> <p>During the 6/29/15 observation period from 4:50 PM until 5:35 PM, two staff were on duty and the House Manager with five (5) clients (clients B, D, E, G, and H) in the group home. Client A was on a home visit with her mother/guardian since being located, client C was on an outing in the community, and client F was on a home visit. On 6/26/15 from 6:05 AM until 7:18 AM, one staff was on duty with seven clients (clients B, C, D, E, F, G, and H) in the group home. On 6/26/15 from 7:18 AM until 7:25 AM, two staff were on duty with seven clients (clients B, C, D, E, F, G, and H) in the group home. Client A was not in the group home. On 6/25/15 from 6:50 AM until 7:50 AM, three staff were on duty with seven clients (clients B, C, D, E, F, G, and H) in the group home. On 6/24/15 from 6:30 AM until 6:45 AM, one staff was on duty with seven clients in the group home. From 6:45 AM until 7:00 AM, one staff and the House Manager were on duty in the group home. From 7:00 AM until 8:10 AM, two staff and the House Manager were on duty in</p>			

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	<p>the group home.</p> <p>During the observation periods staff on duty indicated they had not received re training on: elopement behaviors, ISP's, BSP's, and interventions to be used to prevent elopement behaviors. During all observation periods clients and staff indicated there had not been client meetings held. Staff re training to implement agency elopement procedures and client A, B, and C's ISP, BSP, and Risk plan were not initiated until 6/30/2015. No client program revisions were available for review during all observation periods. Documented administrative oversight, implementation of the agency's Immediate Jeopardy Plan, and monitoring of the group home was not documented until 6/30/15.</p> <p>Review of the facility's staffing schedule on 6/29/15 at 5:30 PM for the week of 6/29/15 indicated in the morning (day shift) two (2) shift staff worked from 7:00 AM until 3:00 PM, in the evening two (2) shift staff worked from 2:00 PM to 10:00 PM, and one (1) shift staff worked from 10:00 PM to 8:30 AM. From previous observation periods on 6/25 and 6/26/15, clients B, C, D, E, F, G, and H arrived home from the workshop at 3:50 PM. On 6/29/15 at 5:30 PM, an interview with the House</p>						

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	<p>Manager (HM) indicated there were supposed to be 2 staff working the evening shift daily and 1 staff working during the overnight periods. The Immediate Jeopardy was not removed.</p> <p>Findings include:</p> <p>Please refer to W149. The facility neglected to ensure implementation of the agency's policy and procedure to prohibit abuse, neglect, mistreatment, and/or exploitation of clients A, B, and C. The facility neglected to protect client A from elopement after a history of elopement behaviors was identified which resulted in sexual assault, substance abuse, and personal injury. The facility neglected to ensure staff were available and competent to supervise and implement client A, B, and C's ISP, BSP, and Risk Plan. The facility failed to develop further safeguards and corrective measures regarding client A, B, and C's continued elopement behaviors and complete thorough investigations for 3 of 3 sampled clients (clients A, B, and C).</p> <p>Please refer to W153. The facility failed to report an allegation of client to client physical aggression to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per</p>			

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W 0149 Bldg. 00	<p>460 IAC 9-3-1(b)(5) and to Adult Protective Services (APS) per IC 12-10-3 for 1 of 1 allegations of abuse and/or neglect reviewed for clients A and B.</p> <p>Please refer to W154. The facility failed to complete thorough investigations for incidents and allegations of abuse, neglect, and/or mistreatment for clients A and B for 1 of 7 BDDS (Bureau of Developmental Disabilities Services) reports reviewed from 3/2015 through 6/24/15 (for client A) and for 1 of 1 allegation not reported (for clients A and B).</p> <p>Please refer to W157. The facility failed to complete effective corrective action to prevent future incidents of elopement and physical aggression behaviors for 3 of 3 sampled clients (clients A, B, and C).</p> <p>This federal tag relates to complaint #IN00176248.</p> <p>9-3-2(a)</p> <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</p>	W 0149	1.The QIDP will receive	07/17/2015

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	<p>interview, for 3 of 3 sampled clients (clients A, B, and C), the facility neglected to ensure implementation of the agency's policy and procedure to prohibit abuse, neglect, mistreatment, and/or exploitation and to complete thorough investigations for clients A, B, and C. The facility neglected to protect client A from elopement after a history of elopement behaviors was identified which resulted in sexual assault, substance abuse, and personal injury. The facility neglected to ensure staff were available and competent to supervise and implement client A, B, and C's ISPs (Individual Support Plan), BSPs (Behavior Support Plan), and Risk Plans. The facility neglected to develop further safeguards and corrective measures regarding client A, B, and C's continued elopement behaviors.</p> <p>Findings include:</p> <p>1. On 6/23/15 from 3:20pm until 5:40pm and on 6/24/15 from 6:30am until 8:10am, observations were completed at the group home and client A was not present.</p> <p>On 6/24/15 at 11:00am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed. The review</p>		<p>retraining on investigations including reporting to the administrator or designee the results within 5 work days and also ensuring that all parties related to the incident are interviewed and that all information regarding the incident (for example if Behavior Support plans were followed or PIA was used) is included in the investigation and so that a thorough investigation can be completed. In addition, the QIDP will ensure that recommendations are made for what staff should do to prevent future incidents. The QIDP will ensure that staff are trained on recommendations and that recommendations are implemented to prevent future incidents from occurring.</p> <p>All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made.</p> <p>The QIDP had a copy of the IDT</p>	

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	<p>indicated the following for client A:</p> <p>-A 6/18/15 BDDS report for an incident on 6/17/15 at 6:00pm indicated "On Wednesday, June 17, 2015 at 5:52pm" the Residential Manager (RM) notified the Qualified Intellectual Disabilities Professional/Program Director (QIDP/PD) that client A "had eloped from her Indiana Mentor Group Home. Of the two staff on shift, one staff was on an outing with other clients in the Group Home and one was behind with the client that eloped (client A) and a few other clients." The report indicated client A eloped and "the one staff member (at the group home) walked to the end of the driveway and watched the client while talking to [the RM]...eventually reporting she could no longer see the client." The report indicated client A arrived at a different all male group home "approximately a 1/2 (half) hour (sic) later; staff was unable to ascertain how she got there...[client A] refused to go back to her Group Home. Police were called and when they arrived, they told the client she had the right to elope and because she was not a threat of harm to herself or those around her, they would leave. Prior to leaving, they (the Police) told [client A] she should go back home which was approximately 7:00pm. [Client A] got into the Group Home van,</p>		<p>notes in an off-site office file for Client A stating when the 1:1 staffing supervision was changed after a prior incident. The QIDP will receive retraining on ensuring that all IDT notes are available for review in client's program books.</p> <p>Client A's ISP and BSP have been updated to include elopement as a targeted behavior. Included in the plans are strategies for staff to use to know how and when to intervene to ensure Client A's safety regarding elopement behaviors.</p> <p>QIDP will receive retraining to include ensuring that all consumers Behavior Support Plans include all identified targeted behaviors and also include strategies for how staff are to address targeted behaviors and prevent future occurrences. A review of all consumers Behavior Support plans will be done to ensure all targeted behaviors are identified in the plans and strategies for how staff should address and prevent targeted behaviors.</p> <p>QIDP has developed a goal for Client A to teach her about personal safety. Client A ISP and Risk plan have been updated to reflect the new goal/objectives. QIDP will receive retraining on ensuring that client specific goals/objectives are developed after a need has been identified</p>	

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	cursing at staff, stating she was going to run away again as soon as she got there (back to her Group Home). [Client A] arrived to (her Group Home) shortly before 8:00pm, still cursing at staff, laughing hysterically, and threatening to run. Both the staff on shift kept [client A] within their sight because of [client A's] threats." The report indicated client A took her 8:00pm medications and "Afterwards, [client A] told the staff to stop following her and then she started to use closed fist punches to one staff member whom was blocking [client A's] way to an exit door. The staff member attempted to use the one arm hold...The second staff was attempting to stop two other clients whom were threatening to elope at the same time. The first staff member released [client A's] arm and [client A] ran out of the home. At that time the [Residential Manager (RM)] was already parked in her car in front of the [Group Home] reporting to the [QIDP/PD] that [client A] was threatening to leave when [client A] did just that...The [RM] turned her car on and followed [client A] down the street and into the apartment complex nearby where [the RM] lost sight of [client A]." The report indicated the RM and the QIDP/PD "drove around for a few minutes," could not locate client A, and called the Police. The report indicated		to assist consumers in working towards independence.  Client A Behavior Support Plan has been updated to include the use of Physical Intervention Alternative (PIA) techniques and what specific techniques to use with Client A to prevent future elopement behaviors. Client A Individual Support Plan (ISP) and Risk Plans have been updated to include changes made regarding PIA in Client A Behavior Support Plan.  All direct care staff will receive retraining on the changes made to Client A Behavior Support plan regarding the specific PIA techniques to use with Client A to prevent future elopement behaviors.  The QIDP will complete an audit of all other consumers Behavior Support Plans to ensure that if the use of PIA is recommended for use to prevent targeted behaviors that specifics of what techniques are recommended are outlined in consumers Behavior Support Plans. If PIA is identified in consumers Behavior Support Plans the QIDP will update the consumers ISP and Risk plans to reflect any changes.  QIDP will receive retraining to include ensuring that if use of PIA techniques is recommended to prevent targeted behaviors that	

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	<p>"the time [client A] eloped was approximately 8:37pm. At this time, [client A] has still not been located by the Police nor Mentor staff assisting in looking for [client A]...." No corrective action was available for review.</p> <p>Summary of Internal Investigative Report dated 6/22/15 indicated the following: -"Brief Summary of incident: On 6/17/15 at 5:52pm, [client A] eloped from the home, was located by staff and returned to the group home. [Client A] eloped a second time after 8pm and was unable to be located. A report was filed with the [Name of Police Agency]."</p> <p>-The investigation indicated those interviewed were three direct care staff, the Residential Manager, and the Program Director. The investigation was not thorough in that the investigation did not indicate completed interviews with clients who were present at the time of each elopement.</p> <p>-"Background of client and their placement...(Client A's diagnoses included but were not limited to:) Mild Intellectual Disability, Traumatic Brain Injury with behavior disturbance, ADHD (Attention Deficit Hyperactivity Disorder), Seizure DO (Disorder)... [Client A's] history of elopement started</p>		<p>the specific of what techniques to use are outlined in consumers Behavior Support Plans, ISP and Risk plans.</p> <p>QIDP has developed a goal for Client A to teach her about personal safety. Client A ISP and Risk plan have been updated to reflect the new goal/objectives. QIDP will receive retraining on ensuring that client specific goals/objectives are developed after a need has been identified to assist consumers in working towards independence.</p> <p>1.All Direct care staff will be receive retraining on incident reporting requirements including what incidents need to be reported, designated timeframes in which incidents are to be reported and the procedure for immediately notifying the on call supervisor of reportable incidents.</p> <p>QIDP will receive retraining to include ensuring that all reportable incidents are documented and BDDS reports are filed within 24 hours of knowledge of the incident.</p> <p>The Home Manager will receive retraining on documentation review including reviewing all consumer Daily support records, behavior tracking and narrative notes to ensure all incidents that have been documented have been reported to the QIDP so</p>	

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	<p>prior to her placement at Indiana Mentor, [client A's] ISP and Risk Plan states she experiences Panic Attacks. On 9/2/14 [client A] was missing for over 12 hours and was found in the bed of a client after entering his home through a window without staff knowledge...[Client A's] mother became her legal guardian on 7/21/14."</p> <p>-"Interview" with the RM indicated she followed client A in her car during client A's second elopement (6/17/15 at 8:37pm) "...when [client A] reached [name of street] [Client A] attempted to dart into traffic so [the RM] used her car to block [client A] from getting hit by other cars as [the RM] pleaded for [client A] to get in [the RM's] car." The RM indicated she followed client A until she entered the apartment complex where the RM lost sight of client A.</p> <p>-"Interview" with Group Home Staff (GHS) #1 indicated she had picked up client A from day services, returned to the group home, and client A had called her mother and family members without making contact on the telephone. GHS #1 indicated client A became upset and "she [client A] was leaving and ran out the door...[GHS #1] was by herself with clients...she was able to see [client A] from the end of the driveway until [client</p>		<p>reports can be made to the Bureau of Developmental Disability Services and investigations can be completed as needed.</p> <p>Ongoing, the Home Manager and/or QIDP will review the DSRs and Behavior tracking records a minimum of twice weekly for 30 days to ensure that all incidents that fall under the BDDS reportable incident guidelines are reported to the on call supervisor, QIDP and/or Area Director within the designated reporting guidelines. After the 30 days, the Home Manager and/or QIDP will review the DSRs and Behavior tracking records a minimum of once per week to ensure that all incidents that fall under the BDDS reportable incident guidelines are reported to the on call supervisor, QIDP and/or Area Director within the designated reporting guidelines.</p> <p>The QIDP will receive retraining on investigations including reporting to the administrator or designee the results within 5 work days and also ensuring that all parties related to the incident are interviewed (including all clients present at the home at the time of the incident) and that all information regarding the incident (for example if Behavior Support plans were followed or PIA was used) is included in the investigation and so that a</p>	

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	<p>A] ducked behind the school...[GHS #1] received call from the [RM] to meet at [the second group home]...[client A] was out of control (when GHS #1 arrived at the second group home)...[GHS #1] said [client A] finally agreed to get in the van, but said she was going to run away again when she got home. [GHS #1] said on the way home [client A] was asked to show them (the staff) where [client A] had knocked on the door and got a ride to [the second group home]. [GHS #1] said [client A] said she knocked on the door, cried, saying she was lost, and needed a ride to [name of second group home]...."</p> <p>- "Interview" with GHS #2 indicated she was out shopping with client E, returned in the van to the group home to find GHS #1 standing in the driveway looking for client A. GHS #2 "said when [client A] returned home she was treated like a rock star by her housemates. [GHS #2] said [client A] was being congratulated, high fived, and generally encouraged for running away. [GHS #2] said there was a lot of commotion and the noise level was high...[Client A] continued to threaten to leave. Attempts to calm [client A] were not successful. [GHS #2] said at about 8:30pm, [client A] ran out the front door and all her housemates ran to the front of the house and cheered her on."</p>		<p>thorough investigation can be completed. In addition, the QIDP will ensure that recommendations are made for what staff should do to prevent future incidents. The QIDP will ensure that staff are trained on recommendations and that recommendations are implemented to prevent future incidents from occurring.</p> <p>All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made.</p> <p>1. Client B BSP has been updated to include the target behavior of elopement, including a description of Client B elopement behavior and has identified client specific strategies for staff to use to prevent future elopement behaviors.</p> <p>QIDP will receive retraining to include ensuring that all consumers Behavior Support Plans include all identified targeted behaviors and also</p>	

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	<p>-"Interview" with the PD (Program Director) indicated "...On 6/22/15 she received a call from [GHS #7] a [substitute staff at the group home] the morning of 6/20/15 (Saturday). [PD] said [GHS #7] informed her that the police had [client A] at 34th (Street) and Meridian St. and was being taken to [Name of Hospital] for evaluation. [PD] said she met [client A] at the emergency room. [PD] said she had only a few minutes alone with [client A] before [client A's] mother arrived. [PD] said [client A] stated she made \$60.00 for sex, but then was forced to take drugs and was passed around for sex, which she did not like. [PD] said [client A's] mother took [client A] home following the forensic evaluation. [PD] said she has applied for the Project Lifesaver (electronic monitoring device), which would not be available for up to two months due to availability."</p> <p>-"Interview" with client A's mother/guardian indicated client A's mother/guardian had been driving to Indianapolis from [name of city] in an attempt to locate client A on the street. Client A's mother/guardian indicated she was tracing telephone calls made by client A when client A called family members out of town and had traced client A who was using other people's</p>		<p>include strategies for how staff are to address targeted behaviors and prevent future occurrences. A review of all consumers Behavior Support plans will be done to ensure all targeted behaviors are identified in the plans and strategies for how staff should address and prevent targeted behaviors.</p> <p>1. Client C's BSP has been updated to include specific instructions for when staff are to utilize the police or other emergency service personnel to intervene regarding Client C SIB, Physical aggression and/or elopement behaviors.</p> <p>QIDP will receive retraining to include ensuring that all consumers Behavior Support Plans are comprehensive and include all identified targeted behaviors and also include strategies for how staff are to address targeted behaviors and prevent future occurrences. A review of all consumers Behavior Support plans will be done to ensure all targeted behaviors are identified in the plans and strategies for how staff should address and prevent targeted behaviors.</p> <p>Area Director will complete an audit of all consumers Behavior Support Plans, ISPs and Risk plans to ensure that specifics of</p>	

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	<p>cell phones which she had borrowed on the street and a pay phone at a bus stop. Client A's mother/guardian indicated she was at the hospital with client A on 6/20/15 after being notified that client A had been found. Client A's mother/guardian indicated client A "told her she (client A) did make \$60.00 from a man who then started pimping [client A] out...(client A) was forced to consume drugs and was passed from person to person including a women for sex...when [client A] told them to stop she was told to get her things and get out...(client A) tested positive for cocaine, opiates, and THC (Tetrahydrocannabinol, a chemical responsible for most of marijuana's psychological effects)...(client A) is experiencing pain with rectal and vaginal bleeding...(Client A) is having panic attacks and nightmares..." Client A's mother/guardian stated "she intends to keep [client A] home until the Project Life Saver can be put into place."</p> <p>-"Conclusion" indicated client A eloped twice on the evening of 6/17/15. Evidence supports physical intervention was not used in order to keep client A from leaving the group home. The investigation was not thorough in that it did not document witness statements from other clients present in the home and during both elopements of client A.</p>		<p>what PIA techniques to use to prevent consumers targeted behaviors and when police or emergency personnel are to be called to intervene with behaviors are specifically outlined in consumers Behavior Support Plans, ISPs and risk plans as needed.</p> <p>For the next three months, the Area Director will review all changes or annual updates made to any consumers Behavior Support plans completed by the QIDP to ensure that specific PIA techniques recommended to use to prevent consumers targeted behaviors and when staff are to utilize emergency personnel to intervene with behaviors is specifically outlined in their BSP, ISP and Risk plans.</p> <p>Ongoing after the three months, the Area Director will complete a random audit of a minimum of 2 consumers per month BSP, ISP and Risk plans developed by the QIDP to ensure that specific PIA techniques recommended to use to prevent consumers targeted behaviors and when staff are to utilize emergency personnel to intervene with behaviors is specifically outlined in their BSP, ISP and Risk plans.</p> <p>Responsible Party: Home Manager, QIDP, Regional Quality Assurance Specialist, Area Director.</p>	

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	<p>The investigation did not indicate recommendations and corrective actions to protect client A and to protect other clients from their identified behaviors.</p> <p>The investigation did not indicate documentation of staff implementing client A's BSP, ISP, or the effectiveness of PIA (Physical Intervention Alternatives) techniques to prevent the incident from escalating from client A's elopement behaviors.</p> <p>Client A's 6/20/15 Hospital Emergency Room Record was reviewed on 6/24/15 at 8:30am. The hospital record "Emergency Room" documentation by the physician indicated "Pt. (Patient) reports that she ran away from group home 3 days ago. She reports she met a man who offered her money, made her smoke spice and marijuana, snorted cocaine. She reports she was sexually assaulted by upward of 7 different men over that time on separate occasions. She reports vaginal, anal, and oral penetration...inflamed skin external genitalia...Assessment: Sexual Assault, medically stable...+ (positive) for cocaine / opiates...pelvic done/evidence collected...given counseling sources... (signed by the physician)." The 6/20/15 "ER Triage Chief Complaint...Drug Abuse, possible Sexual Assault of adult." Client A's 6/20/15 "EMS (Emergency</p>			

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	<p>Medical Services) Incident" document indicated "9-1-1 dispatched for injured person...found 19 yo/w/f (year old/white/female) ambulatory on scene with [Police]. [Police] stated that pt. (patient) was found laying on the ground in the doorway of a hallway to an apartment building with many bystanders around. [Client A] told [Police] that she walked away from her group home (and) she stays there due to a previous brain injury. On June 17th and (sic) was picked up by a couple of guys. According to [Police], after that the men gave her crack cocaine, pt. states she snorted and smoked it and (they) physically sexually assaulted her. Pt. claims to have not slept since Tuesday and last used crack cocaine about 20 minutes prior to being found by [Police]. Her only complaint was that her face was numb, she was having tingling in her upper extremities, and she was sleepy from having not slept since Tuesday. [Police] notified representatives from her group home enroute to [name of hospital]. [Client A] started to feel nauseous but did not vomit until we started to pull into the ambulance bay at [name of hospital]...."</p> <p>Confidential Interview (CI) #1 stated on 6/20/15 client A was "filthy dirty," was not wearing client A's personal clothing,</p>			

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	<p>was not wearing underwear, was not wearing a bra, and had injuries to her face, chest, and genitalia.</p> <p>CI #2 stated client A "does not understand consent and could not give consent." CI #2 stated client A had "told (CI #2) that she was passed around from man to man and some women" for sex. CI #2 indicated client A told her she left the group home the second time on 6/17/15, hitchhiked to [name of neighborhood], walked the streets, met the man who told client A she was pretty, and that he could show client A how to make money. CI #2 indicated client A told CI #2 that the man had sex with client A multiple times, passed her to other men and women for sex to exchange for money, lived on the streets of Indianapolis, consumed cocaine, marijuana, and opiates. CI #2 indicated on Saturday, 6/20/15 client A said she was asked to step outside an apartment during a visit to a new location with the unknown man, client A stepped outside the apartment in the doorway, sat down, fell asleep, and woke up with the Police Officers looking at her.</p> <p>Client A's record was reviewed on 6/24/15 at 11:50am. -Client A's 5/4/15 ISP indicated client A had "targeted behaviors" which included:</p>			

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	<p>Panic Attacks, Inappropriate interaction with males, and vacating (elopement) behaviors. Client A's ISP indicated she had elopement behaviors 9/2/14 when client A "was discovered to have eloped from her group home. She was found on 9/3/14 at 8:15am at a [name of group home] that of her alleged boyfriend... [Client A] had consensual sex with her alleged boyfriend and also went to sleep next to him during the night...9/24/14 [client A] was found under her bedroom covers with two other clients whom alleged that sexual misconduct had taken place in the form of her (female) housemate touching her in the breast and vagina area. The allegation could not be substantiated...10/18/14 at 8:00pm, [client A] successfully eloped from the group home and was later found at her (different) boyfriend's [name of group home] at 8:28pm. She willingly transported back to her group home but threatened to elope again...2/17/15 stayed in a hotel all night and day with her (different) boyfriend while on a home visit in [name of city]...." Client A's ISP did not include proactive measures and objectives to teach client A protective measures regarding personal safety, elopement, and safety skills. Client A's ISP indicated she required twenty-four hour a day staff supervision.</p>			

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	<p>-Client A's 10/18/14, 9/24/14, and 9/2/14 IDT (Interdisciplinary Team) meeting notes indicated "1:1 (One on One) staff supervision" was implemented after each incident of elopement and did not indicate when the one on one staff supervision was changed.</p> <p>-Client A's 5/4/2015 "Risk Management Assessment and Plan" indicated client A "Presents a risk" for the following areas of assessment: "Wears glasses...Some balance issues due to her left leg being somewhat shorter than her right, walks with a limp...slight weakness in her hand...is not able to administer medications independently...panic attacks...(does not) associate consequences with actions [client A] has a history of inappropriate interactions with males as well as placing herself in potentially dangerous situations in her interactions with males. Would benefit from 24/7 supervision to ensure her health and safety and general welfare... (does not) inform support person (the staff) of plans when leaving home area. [Client A] has history of elopement...would readily get into a car with a man she does not know if he paid attention to her...(does not) exhibit socially accepted behaviors in public... (does not) have ability to remain alone in any environment. [Client A] lacks the</p>			

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	<p>ability to do this independently... Would not likely defend herself...may not be able to recognize what is considered abuse and therefore not report appropriately...[Client A] needs assistance with her finances...has a history of cutting herself...[Client A] requires 24 hour awake supervision."</p> <p>-Client A's 2/2014 BSP indicated identified targeted behaviors of Panic Attack, Inappropriate with males, and vacating (elopement). Client A's BSP indicated "Vacating...Staff should be aware of [client A's] whereabouts at all times...If [client A] elopes from staff, keep her in sight and calmly request that she make a positive choice, and return to the home or vehicle with you...If [client A] appears upset ask her if she wants to talk about what is bothering her, or if she needs time to be alone to calm herself down. If she refuses to return, calmly request again that she return to the location that she eloped from. Continue to follow her, but do not make a big deal out of it, do not discuss the situation further. Give [client A] time to think about it, 15 min. (minutes), while you are following her and monitoring for safety. If [client A] refuses after 15 minutes to return, offer her another opportunity to return, if she continues to refuse after this offer, contact the PD (Program</p>			

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	<p>Director) or PD (Program Director) on call for further instruction, do not inform [client A] that you are contacting the PD, do not make a fuss or a big deal about contacting the PD. If [client A's] elopement has put her in a potentially dangerous situation in a high traffic area, implement least restrictive agency approved physical intervention (PIA) to maintain safety. If possible a staff member that is not actively intervening with [client A] contact the PD...." Client A's BSP did not include the agency's definition for PIA.</p> <p>On 6/24/15 at 12:30pm, the facility's undated "Physical Intervention Alternatives" policy and procedure located in the staff communication book for "Physical restraint: All Indiana Mentor staff are trained upon employment and re-trained annually on these procedures. Any escorts/restraints should be released as quickly as possible. If a restraint lasts for 10 minutes, the client should be released and staff should attempt blocking/avoidance unless it is unsafe to do so. If blocking/avoidance continues to be ineffective or unsafe, reinstate physical restraint for 10 minute intervals attempting to release the client when it is safe to do so. If a client does not respond to proactive measures or non-restrictive measures use restrictive</p>			

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	<p>company approved PIA (Physical Intervention Alternatives) techniques listed in this order: Physical restraints should be used only when physical aggression will likely result in harm to oneself, others, or when property destruction might affect peoples' health and safety otherwise use blocking/avoidance. Staff may skip less restrictive measure only if health/safety is an imminent threat. Escorts: Side by side escort walking slightly behind and to the side of the person. Hand below elbow 'L' shaped hand cupping the elbow. Hand behind elbow and hand mid-back. Restraints only to be used if blocking, avoidance or escort is not safe. One arm hold uses 'L' shaped hand to restrict one of the client's arms. Two arm hold, same as one arm but uses second arm to restrain client's flailing arm to the side still only restraining one arm. One arm hold to the floor-client in sitting position. Floor hold (two person) use one arm to the floor restraint, second staff used to restrain legs of the client."</p> <p>On 6/24/15 at 10:30am, an interview was conducted with the QIDP/PD. The QIDP/PD stated client A did not recognize danger, "required" twenty-four hour staff supervision, and had eloped from the group home on 6/17/15. The QIDP/PD indicated client A's ISP, BSP,</p>			

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	and risk plans should have been implemented on 6/17/15. The QIDP/PD indicated the facility's abuse and neglect policy should be implemented, the investigations of allegations of abuse, neglect or mistreatment should be thorough and recommendations should be developed and implemented to prevent recurrence of incidents of abuse, neglect or mistreatment. The QIDP/PD stated she was filling out the paperwork for the application of client A's Protect Life Saver program and indicated after the application was submitted it "would be at least two months or longer" before client A would be available for the program. When asked what protective measures and corrective actions had been developed after client A's continued elopement behaviors, the QIDP/PD stated "We added one on one staff" supervision. When asked why client A did not have one on one staff supervision on 6/17/15, the QIDP/PD indicated there were two (2) staff in the home on the schedule and one of the two was gone with client E on a community outing which left one staff alone with seven (7) clients. The QIDP/PD indicated there were three (3) additional clients living in the group home who were elopement risks. The QIDP/PD stated she was "unsure" when client A's one on one staff supervision was discontinued. The			

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	<p>QIDP/PD stated client A "did not recognize danger," "required staff supervision," and was "unsafe" when she runs into traffic on the streets during elopements on 6/17/15. The QIDP/PD indicated client A's ISP, BSP, and Risk Plans did not document proactive strategies to protect and to teach client A regarding personal safety and elopement.</p> <p>2. On 6/25/15 at 10:15 AM, an interview with the QIDP/PD was conducted. The QIDP/PD stated she was made aware of an incident on 6/17/15 before client A had left on her elopement "the first time." The QIDP/PD stated she was in the process of starting an investigation into that event when client A left on elopement the first time, then left on the second elopement, and was "attempting to locate" client A in the community. The QIDP/PD stated she "failed to report to BDDS and failed to investigate" client A's original incident documented in her DSR (Daily Service Record). The QIDP/PD provided an incomplete investigation summary which indicated "Date/Time of Incident: 6/17/15 10:04am...Brief Summary of Incident: [client A] and [client B] had a physical altercation while in the van as the home was preparing to exit for morning transport." The investigation indicated the House Manager had indicated to the</p>			

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	<p>QIDP/PD that she would "give the details later" of what occurred and indicated client A had left the group home "and did not return" to the group home. The investigation did not include witness statements, a review of client information, and/or a review of the events of the occurrence. No corrective action was available for review.</p> <p>On 6/25/15 at 10:15am, the QIDP/PD provided a review of client A and B's DSRs: -Client A's 6/17/15 DSR indicated on "6/17/15 from 7am-3pm, Housemates began to argue. Staff verbally intervened. [Client A] picked up a water bottle and threw it at her housemate [client B], hitting [client B] in the head. Staff was between the two clients attempting to keep distance between them, the housemate [client B] with the water bottle pushed staff toward and grabbed [client A] by the hair. Staff was getting hit from behind in the back and shoulder as [client B] attempted to punch [client A]. Staff used PIA (Physical Intervention Alternatives) during the altercation to release housemates hand from the hair grab. [Client A] was bent down and staff saw her glasses come off and fall to the floor. During this moment staff heard the back door open and housemate [client B] was no longer against staffs back. [Client</p>			

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	<p>A] began yelling and exited the van through the front passenger door. [Client A] was out of the van for several minutes with another staff when [client A] returned she was calm."</p> <p>-Client B's 6/17/15 DSR indicated on 6/17/15 client B was involved in verbal altercations with multiple clients in the morning hours and "was verbally redirected when she continued calling a client a b----" and on "6/17/15 from 7am-3:00pm, The other client threw a water bottle and hit [client B] in the head. [Client B] grabbed the other client by the hair and pushed her body against back of the staff member standing between them...She attempted to hit the client (client A)."</p> <p>3. For client B: -A 4/29/15 BDDS report for an incident on 4/28/15 at 5:10pm indicated client B returned from a psychiatric appointment "agitated that she was having a med (medication) increase. Shortly later, she was prompted by staff to turn her music down." The report indicated client B "responded by flipping the living room table and charging the staff." The report indicated client B "eloped out the front door where staff watched her from the front porch. Staff watched [client B] go to the neighbor's house on both sides of</p>			

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	<p>the group home, knocking on their doors, staff had client in sight from the group home front porch. Finally, a person answered the door to one of the houses and [client B] went inside where staff lost sight of her. At that time, [the PD/QIDP] was notified. Client returned to the group home site within 2 minutes stating she called her sister." The report indicated client B told the PD/QIDP that the staff on duty at the group home had "pushed [client B] and that was why she had to go call her sister...Plan to resolve...Client's plan to be changed to include that of Elopement." No corrective action was available for review.</p> <p>On 6/24/15 at 2:40pm and on 6/25/15 at 8:25am, client B's record was reviewed. Client B's 9/2014 BSP did not include elopement behaviors. An additional non HRC (Human Rights Committee) pending approvals for 4/28/15 BSP and 4/28/15 ISP included elopement behavior on the list of targeted behaviors and did not include interventions staff should use and did not include a written description of client B's elopement behavior.</p> <p>An interview was conducted with PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) on 6/25/15 at 10:15 AM. PD/QIDP indicated client B's BSP should include</p>			

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	<p>specific instructions and/or interventions regarding what staff should do when client B elopes. The PD/QIDP indicated client B should be supervised by facility staff twenty-four hours a day seven days a week.</p> <p>4. For client C: -A 5/15/15 BDDS report for an incident on 5/14/15 at 5:50 PM indicated, "At 5:50 PM, the PD (Program Director) was notified that [client C] had left the premises of the group home walking on the sidewalk. [The PD] informed the staff they would arrive to (sic) the site in 25-30 minutes to assist. Staff reported they stayed with the [client C], walking down the street sidewalk of the group home, continuing to follow and attempt(ing) to redirect [client C] when [client C] turned onto [road] a busy street. At that time, [client C] stepped off the sidewalk and into the street, back and forth numerous times in an unsafe manner. The staff was able to guide [client C] back onto the sidewalk each time, however, felt that [client C] was attempting to harm themselves (sic) so the staff member called 911. Police intercepted the client when she was walking on [street] near [street]. Police called the group home, requesting the second staff member, working that night and attending to the other clients, pick</p>			
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	<p>[client C] and the first staff member up from their position. The second staff member gathered up the clients she was caring for, placed them into the van and picked up the did so (sic). [PD #1] arrived to (sic) the site at 6:20 PM to find that [client C] had been brought back to the site by staff who picked her up from police and the first staff member's care." No corrective action was available for review.</p> <p>-A 4/13/15 BDDS report for an incident on 4/12/15 at 10:45 PM indicated, "[HM (Home Manager)] called (the) on-call [PD] to report that [client C] had walked away from the group home. Staff called 911 for additional supports and when staff hung up the phone, [client C] was back at the group home. [Client C] was out of staff's sight for 2 minutes before returning back to (the) group home." No corrective action was available for review.</p> <p>-A 3/7/15 BDDS report indicated, "At 6:45 PM, [PD] was notified by staff that 911 had been called from the group home due to [client C's] physical aggression toward staff. Prior to the 911 call, staff prompted [client C] to pick up the piles of clothes all around her bed and start washing them or hanging them up if they were clean. [Client C] started to yell</p>			

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	<p>loudly that she was not going to clean up her room. The staff then started picking up the clothes that smelled of urine and started to walk out of her room to the washing machine. At that time and just as the staff member was exiting [client C's] room, [client C] put both of her hands on the staff, proceeded to punch her with both closed fists multiple times. The second staff then ran down the hall to [client C's] room and attempted to put herself in between [client C] and the staff member getting hit but [client C] kept reaching around her and punching the first staff member whom was on the bedroom floor. The second staff member continued to use two hand blocks to keep both staff safe. Sometime during this altercation another client in the home proceeded to call 911 of their own accord. [Client C] continued physical aggression until shortly before the police showed up to the group home about 5 minutes after she hit staff the first time. [Client C] was questioned by the police, told to stop her behavior and the police left. As soon as they left, [client C] started threatening to harm herself, yelling and pacing the home without ceasing for 20 minutes straight. During those 20 minutes she was reaching for items, saying she was going to cut herself. At that time, staff felt they could not keep themselves nor [client C's]</p>			

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	<p>housemates safe, so staff called 911 again. Upon the arrival of police for the second time, [client C] was taken to [hospital]." No corrective action was available for review.</p> <p>Client C's record was reviewed on 6/24/15 at 2:00 PM. Client C's 9/20/14 BSP indicated the following:</p> <p>- "Response Measures- SIB. If staff observed [client C] engaging in SIB, request that she stop the behavior. If she stops the SIB, thank her. Request that [client C] then engage in a leisure activity or utilize her coloring sheets. If [client C] would like to talk with staff, staff should allow [client C] time to discuss her concern or frustration. If [Client C] continues the behavior after being requested to stop and the behavior is not causing her physical harm, i.e. scratching at skin without breaking skin, pinching herself etc., ignore the behavior but not [client C]. Continue to monitor [client C] for the SIB to escalate. Request that [client C] engage in another activity with you. It is important that she engage with staff at this time. Staff should color with her, go for a walk, play a game etc. with [client C]. If steps above are unsuccessful and the SIB is a threat to [client C's] safety, use the least amount of agency approved physical intervention</p>			

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	<p>(PIA) to stop the SIB. Inform the PD (or PD on-call." The review did not indicate documentation of when staff should utilize police or other emergency service personnel to intervene regarding client C's SIB.</p> <p>-"Aggressive Outburst: (1.) Immediately request that [client C] cease the behavior. Request that she calm herself down. Inform [client C] that once she is calm, you will spend time with her talking about what is upsetting her. Allow her to tell you what she is upset about. All you need to do is listen to her. When she has finished encourage her and engage with her in an activity such as coloring, exercise or playing a game; (2.) If the behavior continues and is directed toward other person in the environment, ask them to leave the area for their own safety. Prompt [client C] to engage in a calming activity; (3.) Do not touch [client C] but tell her she will be okay, ask her what you can do to assist her with calming down; (4.) If [client C] is unable or unwilling to calm down or if the outburst is a danger to self or others proceed to step 5; (5.) Direct [client C] to discontinue the behavior immediately; (6.) If the aggressive outburst continues and is a risk of injury to self or others use the agency approved minimum amount of physical guidance necessary to stop the</p>			

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	<p>behavior. Use the techniques taught by Indiana Mentor (PIA)." The review did not indicate documentation of when staff should utilize police or other emergency service personnel to intervene regarding client C's aggressive outburst/aggression.</p> <p>- "Vacating. Staff should be aware of [client C's] whereabouts at all times. In inclement weather, keep protective clothing for staff and [client C] near the door so that it is easily available if [client C] exits the home. If [client C] elopes from staff, keep her in sight and calmly request that she make a positive choice and return to the home or vehicle with you. (3.) (sic) If [client C] responds, thank her for returning and continue with the activity or outing that was going on previous to her elopement. If [client C] appears upset ask her if she wants to talk about what is bothering her or if she needs time to be alone to calm herself down. (4.) If she refuses to return, calmly request again that she return to the location that she eloped from. Continue to follow her but do not make a big deal out of it, do not discuss the situation further. Give [client C] time to think about it (15 minutes) while you are following her and monitoring for safety. (5.) If [client C] refuses after 15 minutes to return, offer her another opportunity to return, if she continues to refuse after this</p>			

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	<p>offer, contact the PD or PD on-call for further instructions." The review did not indicate documentation of when staff should utilize police or other emergency service personnel to intervene regarding client C's elopement behaviors.</p> <p>Client C's 5/4/15 "Risk Management Plan" indicated client C did not "associate consequences with actions, [client C] receives 24/7 (twenty-four hours and day seven days a week) staff support and supervision...[client C] is impulsive and can be defiant...[client C] will not be unattended in the community...law enforcement may get involved due to elopement."</p> <p>An interview was conducted with PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) on 6/25/15 at 10:15 AM. PD/QIDP indicated client C's BSP should include specific instructions or interventions regarding when staff should utilize police or other emergency service personnel to intervene regarding client C's SIB, physical aggression or elopement behaviors. PD/QIDP indicated client C's police involvement component was indicated on client C's Risk Plan.</p> <p>The facility's policy and procedures were reviewed on 6/24/15 at 10:15am. The</p>			

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W 0153  Bldg. 00	<p>facility's 4/2011 Quality and Risk Management policy indicated "Indiana Mentor promotes a high quality of service and seeks to protect individuals receiving Indiana Mentor services thorough oversight of management procedures and company operations, close monitoring of service delivery and through a process of identifying, evaluating and reducing risk to which individuals are exposed." The 4/2011 Quality and Risk Management Policy indicated failure to provide appropriate supervision, care or training was considered neglect. The 4/2011 Quality and Risk Management Policy indicated, "Indiana Mentor is committed to completing a thorough investigation for any event out of the ordinary which jeopardizes the health and safety of any individual served or or other employee. (1.) Investigation findings will be submitted to the AD (Area Director) for review wand development of further recommendations as needed within 5 days of the incident."</p> <p>This federal tag relates to complaint #IN00176248.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as</p>			

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	<p>injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on interview and record review for 1 of 1 allegations of abuse and/or neglect reviewed for clients A and B, the facility failed to report an allegation of client to client physical aggression to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1(b)(5) and to Adult Protective Services (APS) per IC 12-10-3.</p> <p>Findings include:</p> <p>On 6/25/15 at 10:15 AM, an interview with the QIDP/PD was conducted. The QIDP/PD stated she was made aware of an incident on 6/17/15 before client A had left on her elopement "the first time." The QIDP/PD stated she was in the process of starting an investigation into that event when client A left on elopement the first time, then left on the second elopement, and was "attempting to locate" client A in the community. The QIDP/PD stated she "failed to report to BDDS and failed to investigate" client A's original incident documented in her DSR (Daily Service Record). The QIDP/PD provided an incomplete investigation summary which indicated</p>	W 0153	<p>All Direct care staff will be receive retraining on incident reporting requirements including what incidents need to be reported, designated timeframes in which incidents are to be reported and the procedure for immediately notifying the on call supervisor of reportable incidents.</p> <p>QIDP will receive retraining to include ensuring that all reportable incidents are documented and BDDS reports are filed within 24 hours of knowledge of the incident.</p> <p>The Home Manager will receive retraining on documentation review including reviewing all consumer Daily support records, behavior tracking and narrative notes to ensure all incidents that have been documented have been reported to the QIDP so reports can be made to the Bureau of Developmental Disability Services and investigations can be completed as needed.</p> <p>Ongoing, the Home Manager and/or QIDP will review the DSRs and Behavior tracking records a minimum of twice weekly for 30 days to ensure that all incidents that fall under the BDDS</p>	07/17/2015

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	<p>"Date/Time of Incident: 6/17/15 10:04am...Brief Summary of Incident: [client A] and [client B] had a physical altercation while in the van as the home was preparing to exit for morning transport." The investigation indicated the House Manager had indicated to the QIDP/PD that she would "give the details later" of what occurred and indicated client A had left the group home "and did not return" to the group home.</p> <p>On 6/25/15 at 10:15am, the QIDP/PD provided a review of client A and B's DSRs: -Client A's 6/17/15 DSR indicated on "6/17/15 from 7am-3pm, Housemates began to argue. Staff verbally intervened. [Client A] picked up a water bottle and threw it at her housemate [client B], hitting [client B] in the head. Staff was between the two clients attempting to keep distance between them, the housemate [client B] with the water bottle pushed staff toward and grabbed [client A] by the hair. Staff was getting hit from behind in the back and shoulder as [client B] attempted to punch [client A]. Staff used PIA (Physical Intervention Alternatives) during the altercation to release housemates hand from the hair grab. [Client A] was bent down and staff saw her glasses come off and fall to the floor. During this moment staff heard the</p>		<p>reportable incident guidelines are reported to the on call supervisor, QIDP and/or Area Director within the designated reporting guidelines. After the 30 days, the Home Manager and/or QIDP will review the DSRs and Behavior tracking records a minimum of once per week to ensure that all incidents that fall under the BDDS reportable incident guidelines are reported to the on call supervisor, QIDP and/or Area Director within the designated reporting guidelines.</p> <p>Responsible Party: Home Manager, QIDP, Area Director</p>		

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	<p>back door open and housemate [client B] was no longer against staffs back. [Client A] began yelling and exited the van through the front passenger door. [Client A] was out of the van for several minutes with another staff when [client A] returned she was calm."</p> <p>-Client B's 6/17/15 DSR indicated on 6/17/15 client B was involved in verbal altercations with multiple clients in the morning hours and "was verbally redirected when she continued calling a client a b----" and on "6/17/15 from 7am-3:00pm, The other client threw a water bottle and hit [client B] in the head. [Client B] grabbed the other client by the hair and pushed her body against back of the staff member standing between them...She attempted to hit the client (client A)."</p> <p>The facility's reportable incident reports were reviewed on 6/24/15 at 11:00 AM. The facility's 3/2015 through 6/24/15 reportable incident reports did not indicate client A and B's physical aggression altercation on 6/17/15 was reported by the facility to BDDS and/or to APS.</p> <p>This federal tag relates to complaint #IN00176248.</p>			

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W 0154 Bldg. 00	<p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, for 1 of 7 BDDS (Bureau of Developmental Disabilities Services) reports reviewed from 3/2015 through 6/24/15 (for client A) and for 1 of 1 allegation of abuse not reported (for clients A and B), the facility failed to complete thorough investigations for allegations of abuse, neglect, and/or mistreatment for clients A and B.</p> <p>Findings include:</p> <p>1. On 6/23/15 from 3:20pm until 5:40pm and on 6/24/15 from 6:30am until 8:10am, observations were completed at the group home and client A was not present.</p> <p>On 6/24/15 at 11:00am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed. The review indicated the following for client A:</p> <p>-A 6/18/15 BDDS report for an incident on 6/17/15 at 6:00pm indicated "On</p>	W 0154	<p>The QIDP will receive retraining on investigations including reporting to the administrator or designee the results within 5 work days and also ensuring that all parties related to the incident are interviewed (including all clients present at the home at the time of the incident) and that all information regarding the incident (for example if Behavior Support plans were followed or PIA was used) is included in the investigation and so that a thorough investigation can be completed. In addition, the QIDP will ensure that recommendations are made for what staff should do to prevent future incidents. The QIDP will ensure that staff are trained on recommendations and that recommendations are implemented to prevent future incidents from occurring.</p> <p>All future incident reports will be reviewed by the Area Director and Regional Quality Assurance Specialist to determine if an investigation needs to be completed. All future investigations will be reviewed for thoroughness by the Area Director and Regional Quality</p>	07/17/2015

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	<p>Wednesday, June 17, 2015 at 5:52pm" the Residential Manager (RM) notified the Qualified Intellectual Disabilities Professional/Program Director (QIDP/PD) that client A "had eloped from her Indiana Mentor Group Home. Of the two staff on shift, one staff was on an outing with other clients in the Group Home and one was behind with the client that eloped (client A) and a few other clients." The report indicated client A eloped and "the one staff member (at the group home) walked to the end of the driveway and watched the client while talking to [the RM]...eventually reporting she could no longer see the client." The report indicated client A arrived at a different all male group home "approximately a 1/2 (half) hour (sic) later; staff was unable to ascertain how she got there...[client A] refused to go back to her Group Home. Police were called and when they arrived, they told the client she had the right to elope and because she was not a threat of harm to herself or those around her, they would leave. Prior to leaving, they (the Police) told [client A] she should go back home which was approximately 7:00pm. [Client A] got into the Group Home van, cursing at staff, stating she was going to run away again as soon as she got there (back to her Group Home). [Client A] arrived to (her Group Home) shortly</p>		<p>Assurance Specialist. If the investigations are not thorough enough the Regional Quality Assurance Specialist will provide immediate feedback to the Program Director and necessary changes will be made.</p> <p>Responsible Party: Home Manager, QIDP, Regional Quality Assurance Specialist, Area Director.</p>	

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	<p>before 8:00pm, still cursing at staff, laughing hysterically, and threatening to run. Both the staff on shift kept [client A] within their sight because of [client A's] threats." The report indicated client A took her 8:00pm medications and "Afterwards, [client A] told the staff to stop following her and then she started to use closed fist punches to one staff member whom was blocking [client A's] way to an exit door. The staff member attempted to use the one arm hold...The second staff was attempting to stop two other clients whom were threatening to elope at the same time. The first staff member released [client A's] arm and [client A] ran out of the home. At that time the [Residential Manager (RM)] was already parked in her car in front of the [Group Home] reporting to the [QIDP/PD] that [client A] was threatening to leave when [client A] did just that...The [RM] turned her car on and followed [client A] down the street and into the apartment complex nearby where [the RM] lost sight of [client A]." The report indicated the RM and the [QIDP/PD] "drove around for a few minutes," could not locate client A, and called the Police. The report indicated "the time [client A] eloped was approximately 8:37pm. At this time, [client A] has still not been located by the Police nor Mentor staff assisting in</p>			

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	<p>looking for [client A]...."</p> <p>Summary of Internal Investigative Report dated 6/22/15 indicated the following: -"Brief Summary of incident: On 6/17/15 at 5:52pm, [client A] eloped from the home, was located by staff and returned to the group home. [Client A] eloped a second time after 8pm and was unable to be located. A report was filed with the [Name of Police Agency]."</p> <p>-The investigation indicated those interviewed were three direct care staff, the Residential Manager, and the Program Director. The investigation was not thorough in that the investigation did not indicate completed interviews with clients who were present at the time of each elopement.</p> <p>-"Background of client and their placement...(Client A's diagnoses included but were not limited to:) Mild Intellectual Disability, Traumatic Brain Injury with behavior disturbance, ADHD (Attention Deficit Hyperactivity Disorder), Seizure DO (Disorder)... [Client A's] history of elopement started prior to her placement at Indiana Mentor, [client A's] ISP and Risk Plan states she experiences Panic Attacks. On 9/2/14 [client A] was missing for over 12 hours and was found in the bed of a client after</p>			

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	<p>entering his home through a window without staff knowledge...[Client A's] mother became her legal guardian on 7/21/14."</p> <p>-"Interview" with the RM indicated she followed client A in her car during client A's second elopement (6/17/15 at 8:37pm) "...when [client A] reached [name of street] [Client A] attempted to dart into traffic so [the RM] used her car to block [client A] from getting hit by other cars as [the RM] pleaded for [client A] to get in [the RM's] car." The RM indicated she followed client A until she entered the apartment complex where the RM lost sight of client A.</p> <p>-"Interview" with Group Home Staff (GHS) #1 indicated she had picked up client A from day services, returned to the group home, and client A had called her mother and family members without making contact on the telephone. GHS #1 indicated client A became upset and "she [client A] was leaving and ran out the door...[GHS #1] was by herself with clients...she was able to see [client A] from the end of the driveway until [client A] ducked behind the school...[GHS #1] received call from the [RM] to meet at [the second group home]...[client A] was out of control (when GHS #1 arrived at the second group home)...[GHS #1] said</p>			

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	<p>[client A] finally agreed to get in the van, but said she was going to run away again when she got home. [GHS #1] said on the way home [client A] was asked to show them (the staff) where [client A] had knocked on the door and got a ride to [the second group home]. [GHS #1] said [client A] said she knocked on the door, cried, saying she was lost, and needed a ride to [name of second group home]...."</p> <p>-"Interview" with GHS #2 indicated she was out shopping with client E, returned in the van to the group home to find GHS #1 standing in the driveway looking for client A. GHS #2 "said when [client A] returned home she was treated like a rock star by her housemates. [GHS #2] said [client A] was being congratulated, high fived, and generally encouraged for running away. [GHS #2] said there was a lot of commotion and the noise level was high...[Client A] continued to threaten to leave. Attempts to calm [client A] were not successful. [GHS #2] said at about 8:30pm, [client A] ran out the front door and all her housemates ran to the front of the house and cheered her on."</p> <p>-"Interview" with the [QIDP/PD (Qualified Intellectual Disabilities Professional/Program Director)] indicated "...On 6/22/15 she received a call from [GHS #7] a [substitute staff at</p>			

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	<p>the group home] the morning of 6/20/15 (Saturday). [PD (Program Director)] said [GHS #7] informed her that the police had [client A] at 34th (Street) and Meridian St. and was being taken to [Name of Hospital] for evaluation. [PD] said she met [client A] at the emergency room. [PD] said she had only a few minutes alone with [client A] before [client A's] mother arrived. [PD] said [client A] stated she made \$60.00 for sex, but then was forced to take drugs and was passed around for sex, which she did not like. [PD] said [client A's] mother took [client A] home following the forensic evaluation. [PD] said she has applied for the Project Lifesaver (electronic monitoring device), which would not be available for up to two months due to availability."</p> <p>-"Interview" with client A's mother/guardian indicated client A's mother/guardian had been driving to Indianapolis from [name of city] in an attempt to locate client A on the street. Client A's mother/guardian indicated she was tracing telephone calls made by client A when client A called family members out of town and had traced client A who was using other people's cell phones which she had borrowed on the street and a pay phone at a bus stop. Client A's mother/guardian indicated she</p>			

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	<p>was at the hospital with client A on 6/20/15 after being notified that client A had been found. Client A's mother/guardian indicated client A "told her she (client A) did make \$60.00 from a man who then started pimping [client A] out...(client A) was forced to consume drugs and was passed from person to person including a women for sex...when [client A] told them to stop she was told to get her things and get out...(client A) tested positive for cocaine, opiates, and THC (Tetrahydrocannabinol, a chemical responsible for most of marijuana's psychological effects)...(client A) is experiencing pain with rectal and vaginal bleeding...(Client A) is having panic attacks and nightmares...." Client A's mother/guardian stated "she intends to keep [client A] home until the Project Life Saver can be put into place."</p> <p>-"Conclusion" indicated client A eloped twice on the evening of 6/17/15. Evidence supports physical intervention was not used in order to keep client A from leaving the group home. The investigation was not thorough in that it did not document witness statements from other clients present in the home and during both elopements of client A. The investigation did not indicate recommendations and corrective actions to protect client A and to protect other</p>			

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	<p>clients from their identified behaviors. The investigation did not indicate documentation of staff implementing client A's BSP, ISP, or the effectiveness of PIA (Physical Intervention Alternatives) techniques to prevent the incident from escalating from client A's elopement behaviors.</p> <p>Client A's 6/20/15 Hospital Emergency Room Record was reviewed on 6/24/15 at 8:30am. The hospital record "Emergency Room" documentation by the physician indicated "Pt. (Patient) reports that she ran away from group home 3 days ago. She reports she met a man who offered her money, made her smoke spice and marijuana, snorted cocaine. She reports she was sexually assaulted by upward of 7 different men over that time on separate occasions. She reports vaginal, anal, and oral penetration...inflamed skin external genitalia...Assessment: Sexual Assault, medically stable...+ (positive) for cocaine / opiates...pelvic done/evidence collected...given counseling sources... (signed by the physician)." The 6/20/15 "ER Triage Chief Complaint...Drug Abuse, possible Sexual Assault of adult." Client A's 6/20/15 "EMS (Emergency Medical Services) Incident" document indicated "9-1-1 dispatched for injured person...found 19 yo/w/f (year</p>			

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	<p>old/white/female) ambulatory on scene with [Police]. [Police] stated that pt. (patient) was found laying on the ground in the doorway of a hallway to an apartment building with many bystanders around. [Client A] told [Police] that she walked away from her group home (and) she stays there due to a previous brain injury. On June 17th and (sic) was picked up by a couple of guys. According to [Police], after that the men gave her crack cocaine, pt. states she snorted and smoked it and (they) physically sexually assaulted her. Pt. claims to have not slept since Tuesday and last used crack cocaine about 20 minutes prior to being found by [Police]. Her only complaint was that her face was numb, she was having tingling in her upper extremities, and she was sleepy from having not slept since Tuesday. [Police] notified representatives from her group home enroute to [name of hospital]. [Client A] started to feel nauseous but did not vomit until we started to pull into the ambulance bay at [name of hospital]...."</p> <p>Confidential Interview (CI) #1 stated on 6/20/15 client A was "filthy dirty," was not wearing client A's personal clothing, was not wearing underwear, was not wearing a bra, and had injuries to her face, chest, and genitalia.</p>			

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	<p>CI #2 stated client A "does not understand consent and could not give consent." CI #2 stated client A had "told (CI #2) that she was passed around from man to man and some women" for sex. CI #2 indicated client A told her she left the group home the second time on 6/17/15, hitchhiked to [name of neighborhood], walked the streets, met the man who told client A she was pretty, and that he could show client A how to make money. CI #2 indicated client A told CI #2 that the man had sex with client A multiple times, passed her to other men and women for sex to exchange for money, lived on the streets of Indianapolis, consumed cocaine, marijuana, and opiates. CI #2 indicated on Saturday, 6/20/15 client A said she was asked to step outside an apartment during a visit to a new location with the unknown man, client A stepped outside the apartment in the doorway, sat down, fell asleep, and woke up with the Police Officers looking at her.</p> <p>Client A's record was reviewed on 6/24/15 at 11:50am. -Client A's 5/4/15 ISP indicated client A had "targeted behaviors" which included: Panic Attacks, Inappropriate interaction with males, and vacating (elopement) behaviors. Client A's ISP indicated she</p>			

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	<p>had elopement behaviors 9/2/14 when client A "was discovered to have eloped from her group home. She was found on 9/3/14 at 8:15am at a [name of group home] that of her alleged boyfriend... [Client A] had consensual sex with her alleged boyfriend and also went to sleep next to him during the night...9/24/14 [client A] was found under her bedroom covers with two other clients whom alleged that sexual misconduct had taken place in the form of her (female) housemate touching her in the breast and vagina area. The allegation could not be substantiated...10/18/14 at 8:00pm, [client A] successfully eloped from the group home and was later found at her (different) boyfriend's [name of group home] at 8:28pm. She willingly transported back to her group home but threatened to elope again...2/17/15 stayed in a hotel all night and day with her (different) boyfriend while on a home visit in [name of city]...." Client A's ISP did not include proactive measures and objectives to teach client A protective measures regarding personal safety, elopement, and safety skills. Client A's ISP indicated she required twenty-four hour a day staff supervision.</p> <p>-Client A's 10/18/14, 9/24/14, and 9/2/14 IDT (Interdisciplinary Team) meeting notes indicated "1:1 (One on One) staff</p>			

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	<p>supervision" was implemented after each incident of elopement and did not indicate when the one on one staff supervision was changed.</p> <p>-Client A's 5/4/2015 "Risk Management Assessment and Plan" indicated client A "Presents a risk" for the following areas of assessment: "Wears glasses...Some balance issues due to her left leg being somewhat shorter than her right, walks with a limp...slight weakness in her hand...is not able to administer medications independently...panic attacks...(does not) associate consequences with actions [client A] has a history of inappropriate interactions with males as well as placing herself in potentially dangerous situations in her interactions with males. Would benefit from 24/7 supervision to ensure her health and safety and general welfare... (does not) inform support person (the staff) of plans when leaving home area. [Client A] has history of elopement...would readily get into a car with a man she does not know if he paid attention to her...(does not) exhibit socially accepted behaviors in public... (does not) have ability to remain alone in any environment. [Client A] lacks the ability to do this independently...Would not likely defend herself...may not be able to recognize what is considered</p>			

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	<p>abuse and therefore not report appropriately...[Client A] needs assistance with her finances...has a history of cutting herself...[Client A] requires 24 hour awake supervision."</p> <p>-Client A's 2/2014 BSP indicated identified targeted behaviors of Panic Attack, Inappropriate with males, and vacating (elopement). Client A's BSP indicated "Vacating...Staff should be aware of [client A's] whereabouts at all times...If [client A] elopes from staff, keep her in sight and calmly request that she make a positive choice, and return to the home or vehicle with you...If [client A] appears upset ask her if she wants to talk about what is bothering her, or if she needs time to be alone to calm herself down. If she refuses to return, calmly request again that she return to the location that she eloped from. Continue to follow her, but do not make a big deal out of it, do not discuss the situation further. Give [client A] time to think about it, 15 min. (minutes), while you are following her and monitoring for safety. If [client A] refuses after 15 minutes to return, offer her another opportunity to return, if she continues to refuse after this offer, contact the PD (Program Director) or PD (Program Director) on call for further instruction, do not inform [client A] that you are contacting the PD,</p>			

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	<p>do not make a fuss or a big deal about contacting the PD. If [client A's] elopement has put her in a potentially dangerous situation in a high traffic area, implement least restrictive agency approved physical intervention (PIA) to maintain safety. If possible a staff member that is not actively intervening with [client A] contact the PD..." Client A's BSP did not include the agency's definition for PIA.</p> <p>On 6/24/15 at 12:30pm, the facility's undated "Physical Intervention Alternatives" policy and procedure located in the staff communication book for "Physical restraint: All Indiana Mentor staff are trained upon employment and re-trained annually on these procedures. Any escorts/restraints should be released as quickly as possible. If a restraint lasts for 10 minutes, the client should be released and staff should attempt blocking/avoidance unless it is unsafe to do so. If blocking/avoidance continues to be ineffective or unsafe, reinstate physical restraint for 10 minute intervals attempting to release the client when it is safe to do so. If a client does not respond to proactive measures or non-restrictive measures use restrictive company approved PIA (Physical Intervention Alternatives) techniques listed in this order: Physical restraints</p>			

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	<p>should be used only when physical aggression will likely result in harm to oneself, others, or when property destruction might affect peoples' health and safety otherwise use blocking/avoidance. Staff may skip less restrictive measure only if health/safety is an imminent threat. Escorts: Side by side escort walking slightly behind and to the side of the person. Hand below elbow 'L' shaped hand cupping the elbow. Hand behind elbow and hand mid-back. Restraints only to be used if blocking, avoidance or escort is not safe. One arm hold uses 'L' shaped hand to restrict one of the client's arms. Two arm hold, same as one arm but uses second arm to restrain client's flailing arm to the side still only restraining one arm. One arm hold to the floor-client in sitting position. Floor hold (two person) use one arm to the floor restraint, second staff used to restrain legs of the client."</p> <p>On 6/24/15 at 10:30am, an interview was conducted with the QIDP/PD. The QIDP/PD stated client A did not recognize danger, "required" twenty-four hour staff supervision, and had eloped from the group home on 6/17/15. The QIDP/PD indicated client A's ISP, BSP, and risk plans should have been implemented on 6/17/15. The QIDP/PD indicated the facility's abuse and neglect</p>			

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	<p>policy should be implemented, the investigations of allegations of abuse, neglect or mistreatment should be thorough and recommendations should be developed and implemented to prevent recurrence of incidents of abuse, neglect or mistreatment. When asked what protective measures and corrective actions had been developed after client A's continued elopement behaviors, the QIDP/PD stated "We added one on one staff" supervision. When asked why client A did not have one on one staff supervision on 6/17/15, the QIDP/PD indicated there were two (2) staff in the home on the schedule and one of the two was gone with client E on a community outing which left one staff alone with seven (7) clients. The QIDP/PD indicated there were three (3) additional clients living in the group home who were elopement risks. The QIDP/PD stated she was "unsure" when client A's one on one staff supervision was discontinued. The QIDP/PD stated client A "did not recognize danger," "required staff supervision," and was "unsafe" when she runs into traffic on the streets during elopements on 6/17/15. The QIDP/PD indicated client A's ISP, BSP, and Risk Plans did not document proactive strategies to protect and to teach client A regarding personal safety and elopement.</p>			

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	<p>2. On 6/25/15 at 10:15 AM, an interview with the QIDP/PD was conducted. The QIDP/PD stated she was made aware of an incident on 6/17/15 before client A had left on her elopement "the first time." The QIDP/PD stated she was in the process of starting an investigation into that event when client A left on elopement the first time, then left on the second elopement, and was "attempting to locate" client A in the community. The QIDP/PD stated she "failed to report to BDDS and failed to investigate" client A's original incident documented in her DSR (Daily Service Record). The QIDP/PD provided an incomplete investigation summary which indicated "Date/Time of Incident: 6/17/15 10:04am...Brief Summary of Incident: [client A] and [client B] had a physical altercation while in the van as the home was preparing to exit for morning transport." The investigation indicated the House Manager had indicated to the QIDP/PD that she would "give the details later" of what occurred and indicated client A had left the group home "and did not return" to the group home. The investigation did not include witness statements, a review of client information, and/or a review of the events of the occurrence.</p>			

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	<p>On 6/25/15 at 10:15am, the QIDP/PD provided a review of client A and B's DSRs:</p> <p>-Client A's 6/17/15 DSR indicated on "6/17/15 from 7am-3pm, Housemates began to argue. Staff verbally intervened. [Client A] picked up a water bottle and threw it at her housemate [client B], hitting [client B] in the head. Staff was between the two clients attempting to keep distance between them, the housemate [client B] with the water bottle pushed staff toward and grabbed [client A] by the hair. Staff was getting hit from behind in the back and shoulder as [client B] attempted to punch [client A]. Staff used PIA (Physical Intervention Alternatives) during the altercation to release housemates hand from the hair grab. [Client A] was bent down and staff saw her glasses come off and fall to the floor. During this moment staff heard the back door open and housemate [client B] was no longer against staffs back. [Client A] began yelling and exited the van through the front passenger door. [Client A] was out of the van for several minutes with another staff when [client A] returned she was calm."</p> <p>-Client B's 6/17/15 DSR indicated on 6/17/15 client B was involved in verbal altercations with multiple clients in the morning hours and "was verbally</p>			

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W 0157 Bldg. 00	<p>redirected when she continued calling a client a b----" and on "6/17/15 from 7am-3:00pm, The other client threw a water bottle and hit [client B] in the head. [Client B] grabbed the other client by the hair and pushed her body against back of the staff member standing between them...She attempted to hit the client (client A)."</p> <p>This federal tag relates to complaint #IN00176248.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview, for 3 of 3 sampled clients (clients A, B, and C), the facility failed to complete effective corrective action to prevent future incidents of elopement and physical aggression behaviors.</p> <p>Findings include:</p> <p>1. On 6/24/15 at 11:00am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed. The review indicated the following for client A:</p>	W 0157	<p>1. Client A</p> <p>1. The QIDP had a copy of the IDT notes in an off-site office file for Client A stating when the 1:1 staffing supervision was changed after a prior incident. The QIDP will receive retraining on ensuring that all IDT notes are available for review in client's program books.</p> <p>1. Client A's ISP and BSP have been updated to include elopement as a targeted behavior. Included in the plans are strategies for staff to use to know how and when to intervene to ensure Client A's safety</p>	07/17/2015

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	-A 6/18/15 BDDS report for an incident on 6/17/15 at 6:00pm indicated "On Wednesday, June 17, 2015 at 5:52pm" the Residential Manager (RM) notified the Qualified Intellectual Disabilities Professional/Program Director (QIDP/PD) that client A "had eloped from her Indiana Mentor Group Home. Of the two staff on shift, one staff was on an outing with other clients in the Group Home and one was behind with the client that eloped (client A) and a few other clients." The report indicated client A eloped and "the one staff member (at the group home) walked to the end of the driveway and watched the client while talking to [the RM]...eventually reporting she could no longer see the client." The report indicated client A arrived at a different all male group home "approximately a 1/2 (half) hour (sic) later; staff was unable to ascertain how she got there...[client A] refused to go back to her Group Home. Police were called and when they arrived, they told the client she had the right to elope and because she was not a threat of harm to herself or those around her, they would leave. Prior to leaving, they (the Police) told [client A] she should go back home which was approximately 7:00pm. [Client A] got into the Group Home van, cursing at staff, stating she was going to run away again as soon as she got there		regarding elopement behaviors.  QIDP will receive retraining to include ensuring that all consumers Behavior Support Plans include all identified targeted behaviors and also include strategies for how staff are to address targeted behaviors and prevent future occurrences. A review of all consumers Behavior Support plans will be done to ensure all targeted behaviors are identified in the plans and strategies for how staff should address and prevent targeted behaviors.  1.QIDP has developed a goal for Client A to teach her about personal safety. Client A ISP and Risk plan have been updated to reflect the new goal/objectives. QIDP will receive retraining on ensuring that client specific goals/objectives are developed after a need has been identified to assist consumers in working towards independence.  <i>1.Client B</i>  Client B BSP has been updated to include the target behavior of elopement, including a description of Client B elopement behavior and has identified client specific strategies for staff to use to prevent future elopement behaviors.	

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	(back to her Group Home). [Client A] arrived to (her Group Home) shortly before 8:00pm, still cursing at staff, laughing hysterically, and threatening to run. Both the staff on shift kept [client A] within their sight because of [client A's] threats." The report indicated client A took her 8:00pm medications and "Afterwards, [client A] told the staff to stop following her and then she started to use closed fist punches to one staff member whom was blocking [client A's] way to an exit door. The staff member attempted to use the one arm hold...The second staff was attempting to stop two other clients whom were threatening to elope at the same time. The first staff member released [client A's] arm and [client A] ran out of the home. At that time the [Residential Manager (RM)] was already parked in her car in front of the [Group Home] reporting to the [PD (Program Director)] that [client A] was threatening to leave when [client A] did just that...The [RM] turned her car on and followed [client A] down the street and into the apartment complex nearby where [the RM] lost sight of [client A]." The report indicated the RM and the PD "drove around for a few minutes," could not locate client A, and called the Police. The report indicated "the time [client A] eloped was approximately 8:37pm. At this time, [client A] has still not been		<p>QIDP will receive retraining to include ensuring that all consumers Behavior Support Plans include all identified targeted behaviors and also include strategies for how staff are to address targeted behaviors and prevent future occurrences. A review of all consumers Behavior Support plans will be done to ensure all targeted behaviors are identified in the plans and strategies for how staff should address and prevent targeted behaviors.</p> <p><i>1. Client C</i></p> <p>Client C's BSP has been updated to include specific instructions for when staff are to utilize the police or other emergency service personnel to intervene regarding Client C SIB, Physical aggression and/or elopement behaviors.</p> <p>QIDP will receive retraining to include ensuring that all consumers Behavior Support Plans are comprehensive and include all identified targeted behaviors and also include strategies for how staff are to address targeted behaviors and prevent future occurrences. A review of all consumers Behavior Support plans will be done to ensure all targeted behaviors are identified in the plans and strategies for how staff should address and prevent targeted</p>	

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	<p>located by the Police nor Mentor staff assisting in looking for [client A]...."</p> <p>Client A's record was reviewed on 6/24/15 at 11:50am.</p> <p>-Client A's 5/4/15 ISP indicated client A had "targeted behaviors" which included: Panic Attacks, Inappropriate interaction with males, and vacating (elopement) behaviors. Client A's ISP indicated she had elopement behaviors 9/2/14 when client A "was discovered to have eloped from her group home. She was found on 9/3/14 at 8:15am at a [name of group home] that of her alleged boyfriend... [Client A] had consensual sex with her alleged boyfriend and also went to sleep next to him during the night...9/24/14 [client A] was found under her bedroom covers with two other clients whom alleged that sexual misconduct had taken place in the form of her (female) housemate touching her in the breast and vagina area. The allegation could not be substantiated...10/18/14 at 8:00pm, [client A] successfully eloped from the group home and was later found at her (different) boyfriend's [name of group home] at 8:28pm. She willingly transported back to her group home but threatened to elope again...2/17/15 stayed in a hotel all night and day with her (different) boyfriend while on a home visit in [name of city]...." Client A's ISP</p>		<p>behaviors.</p> <p>Area Director will complete an audit of all consumers Behavior Support Plans, ISPs and Risk plans to ensure that specifics of what PIA techniques to use to prevent consumers targeted behaviors and when police or emergency personnel are to be called to intervene with behaviors are specifically outlined in consumers Behavior Support Plans, ISPs and risk plans as needed.</p> <p>For the next three months, the Area Director will review all changes or annual updates made to any consumers Behavior Support plans completed by the QIDP to ensure that specific PIA techniques recommended to use to prevent consumers targeted behaviors and when staff are to utilize emergency personnel to intervene with behaviors is specifically outlined in their BSP, ISP and Risk plans.</p> <p>Ongoing after the three months, the Area Director will complete a random audit of a minimum of 2 consumers per month BSP, ISP and Risk plans developed by the QIDP to ensure that specific PIA techniques recommended to use to prevent consumers targeted behaviors and when staff are to utilize emergency personnel to intervene with behaviors is specifically outlined in their BSP,</p>	

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	<p>did not include proactive measures and objectives to teach client A protective measures regarding personal safety, elopement, and safety skills. Client A's ISP indicated she required twenty-four hour a day staff supervision.</p> <p>-Client A's 10/18/14, 9/24/14, and 9/2/14 IDT (Interdisciplinary Team) meeting notes indicated "1:1 (One on One) staff supervision" was implemented after each incident of elopement and did not indicate when the one on one staff supervision was changed.</p> <p>-Client A's 2/2014 BSP indicated identified targeted behaviors of Panic Attack, Inappropriate with males, and vacating (elopement). Client A's BSP indicated "Vacating...Staff should be aware of [client A's] whereabouts at all times...If [client A] elopes from staff, keep her in sight and calmly request that she make a positive choice, and return to the home or vehicle with you...If [client A] appears upset ask her if she wants to talk about what is bothering her, or if she needs time to be alone to calm herself down. If she refuses to return, calmly request again that she return to the location that she eloped from. Continue to follow her, but do not make a big deal out of it, do not discuss the situation further. Give [client A] time to think</p>		<p>ISP and Risk plans.</p> <p>Responsible Party: Home Manager, QIDP, Regional Quality Assurance Specialist, Area Director.</p>	

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	<p>about it, 15 min. (minutes), while you are following her and monitoring for safety. If [client A] refuses after 15 minutes to return, offer her another opportunity to return, if she continues to refuse after this offer, contact the PD (Program Director) or PD (Program Director) on call for further instruction, do not inform [client A] that you are contacting the PD, do not make a fuss or a big deal about contacting the PD. If [client A's] elopement has put her in a potentially dangerous situation in a high traffic area, implement least restrictive agency approved physical intervention (PIA) to maintain safety. If possible a staff member that is not actively intervening with [client A] contact the PD...." Client A's BSP did not include the agency's definition for PIA.</p> <p>On 6/24/15 at 10:30am, an interview was conducted with the QIDP/PD. The QIDP/PD stated client A did not recognize danger, "required" twenty-four hour staff supervision, and had eloped from the group home on 6/17/15. The QIDP/PD indicated client A's ISP, BSP, and risk plans should have been implemented on 6/17/15.</p> <p>The QIDP/PD indicated the facility's abuse and neglect policy should be implemented and recommendations</p>			

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	<p>should be developed and implemented to prevent recurrence of incidents of abuse, neglect or mistreatment. The QIDP/PD stated she was filling out the paperwork for the application of client A's Protect Life Saver program and indicated after the application was submitted it "would be at least two months or longer" before client A would be available for the program. When asked what protective measures and corrective actions had been developed after client A's continued elopement behaviors, the QIDP/PD stated "We added one on one staff" supervision. When asked why client A did not have one on one staff supervision on 6/17/15, the QIDP/PD indicated there were two (2) staff in the home on the schedule and one of the two was gone with client E on a community outing which left one staff alone with seven (7) clients. The QIDP/PD indicated there were three (3) additional clients living in the group home who were elopement risks. The QIDP/PD stated she was "unsure" when client A's one on one staff supervision was discontinued. The QIDP/PD stated client A "did not recognize danger," "required staff supervision," and was "unsafe" when she runs into traffic on the streets during elopements on 6/17/15. The QIDP/PD indicated client A's ISP, BSP, and Risk Plans did not document proactive</p>			

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	<p>strategies to protect and to teach client A regarding personal safety and elopement.</p> <p>2. For client B: -A 4/29/15 BDDS report for an incident on 4/28/15 at 5:10pm indicated client B returned from a psychiatric appointment "agitated that she was having a med (medication) increase. Shortly later, she was prompted by staff to turn her music down." The report indicated client B "responded by flipping the living room table and charging the staff." The report indicated client B "eloped out the front door where staff watched her from the front porch. Staff watched [client B] go to the neighbor's house on both sides of the group home, knocking on their doors, staff had client in sight from the group home front porch. Finally, a person answered the door to one of the houses and [client B] went inside where staff lost sight of her. At that time, [the PD/QIDP] was notified. Client returned to the group home site within 2 minutes stating she called her sister." The report indicated client B told the PD/QIDP that the staff on duty at the group home had "pushed [client B] and that was why she had to go call her sister...Plan to resolve...Client's plan to be changed to include that of Elopement."</p> <p>On 6/24/15 at 2:40pm and on 6/25/15 at</p>			

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	<p>8:25am, client B's record was reviewed. Client B's 9/2014 BSP did not include elopement behaviors. An additional non approved HRC (Human Rights Committee) 4/28/15 BSP and 4/28/15 ISP included elopement behavior on the list of targeted behaviors and did not include interventions staff should use and did not include a written description of client B's elopement behavior.</p> <p>An interview was conducted with PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) on 6/25/15 at 10:15 AM. PD/QIDP indicated client B's BSP should include specific instructions and/or interventions regarding what staff should do when client B elopes. The PD/QIDP indicated client B should be supervised by facility staff twenty-four hours a day seven days a week. The QIDP/PD indicated client B's incident did not include corrective action and/or recommendation to protect client B from future incidents.</p> <p>3. For client C: -A 5/15/15 BDDS report for an incident on 5/14/15 at 5:50 PM indicated, "At 5:50 PM, the PD (Program Director) was notified that [client C] had left the premises of the group home walking on the sidewalk. [The PD] informed the staff they would arrive to (sic) the site in</p>			

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	<p>25-30 minutes to assist. Staff reported they stayed with the [client C], walking down the street sidewalk of the group home, continuing to follow and attempt(ing) to redirect [client C] when [client C] turned onto [road] a busy street. At that time, [client C] stepped off the sidewalk and into the street, back and forth numerous times in an unsafe manner. The staff was able to guide [client C] back onto the sidewalk each time, however, felt that [client C] was attempting to harm themselves (sic) so the staff member called 911. Police intercepted the client when she was walking on [street] near [street]. Police called the group home, requesting the second staff member, working that night and attending to the other clients, pick [client C] and the first staff member up from their position. The second staff member gathered up the clients she was caring for, placed them into the van and picked up the did so (sic). [PD #1] arrived to (sic) the site at 6:20 PM to find that [client C] had been brought back to the site by staff who picked her up from police and the first staff member's care." No corrective action was available for review.</p> <p>-A 4/13/15 BDDS report for an incident on 4/12/15 at 10:45 PM indicated, "[HM (Home Manager)] called (the) on-call</p>			

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	<p>[PD] to report that [client C] had walked away from the group home. Staff called 911 for additional supports and when staff hung up the phone, [client C] was back at the group home. [Client C] was out of staff's sight for 2 minutes before returning back to (the) group home." No corrective action was available for review.</p> <p>-A 3/7/15 BDDS report indicated, "At 6:45 PM, [PD] was notified by staff that 911 had been called from the group home due to [client C's] physical aggression toward staff. Prior to the 911 call, staff prompted [client C] to pick up the piles of clothes all around her bed and start washing them or hanging them up if they were clean. [Client C] started to yell loudly that she was not going to clean up her room. The staff then started picking up the clothes that smelled of urine and started to walk out of her room to the washing machine. At that time and just as the staff member was exiting [client C's] room, [client C] put both of her hands on the staff, proceeded to punch her with both closed fists multiple times. The second staff then ran down the hall to [client C's] room and attempted to put herself in between [client C] and the staff member getting hit but [client C] kept reaching around her and punching the first staff member whom was on the</p>			

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	<p>bedroom floor. The second staff member continued to use two hand blocks to keep both staff safe. Sometime during this altercation another client in the home proceeded to call 911 of their own accord. [Client C] continued physical aggression until shortly before the police showed up to the group home about 5 minutes after she hit staff the first time. [Client C] was questioned by the police, told to stop her behavior and the police left. As soon as they left, [client C] started threatening to harm herself, yelling and pacing the home without ceasing for 20 minutes straight. During those 20 minutes she was reaching for items, saying she was going to cut herself. At that time, staff felt they could not keep themselves nor [client C's] housemates safe, so staff called 911 again. Upon the arrival of police for the second time, [client C] was taken to [hospital]." No corrective action was available for review.</p> <p>Client C's record was reviewed on 6/24/15 at 2:00 PM. Client C's 9/20/14 BSP indicated the following:</p> <p>-"Response Measures- SIB. If staff observed [client C] engaging in SIB, request that she stop the behavior. If she stops the SIB, thank her. Request that [client C] then engage in a leisure activity</p>			

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	<p>or utilize her coloring sheets. If [client C] would like to talk with staff, staff should allow [client C] time to discuss her concern or frustration. If [Client C] continues the behavior after being requested to stop and the behavior is not causing her physical harm, i.e. scratching at skin without breaking skin, pinching herself etc., ignore the behavior but not [client C]. Continue to monitor [client C] for the SIB to escalate. Request that [client C] engage in another activity with you. It is important that she engage with staff at this time. Staff should color with her, go for a walk, play a game etc. with [client C]. If steps above are unsuccessful and the SIB is a threat to [client C's] safety, use the least amount of agency approved physical intervention (PIA) to stop the SIB. Inform the PD (or) PD on-call." The review did not indicate documentation of when staff should utilize police or other emergency service personnel to intervene regarding client C's SIB.</p> <p>-"Aggressive Outburst: (1.) Immediately request that [client C] cease the behavior. Request that she calm herself down. Inform [client C] that once she is calm, you will spend time with her talking about what is upsetting her. Allow her to tell you what she is upset about. All you need to do is listen to her. When she has</p>			

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	<p>finished encourage her and engage with her in an activity such as coloring, exercise or playing a game; (2.) If the behavior continues and is directed toward other person in the environment, ask them to leave the area for their own safety. Prompt [client C] to engage in a calming activity; (3.) Do not touch [client C] but tell her she will be okay, ask her what you can do to assist her with calming down; (4.) If [client C] is unable or unwilling to calm down or if the outburst is a danger to self or others proceed to step 5; (5.) Direct [client C] to discontinue the behavior immediately; (6.) If the aggressive outburst continues and is a risk of injury to self or others use the agency approved minimum amount of physical guidance necessary to stop the behavior. Use the techniques taught by Indiana Mentor (PIA)." The review did not indicate documentation of when staff should utilize police or other emergency service personnel to intervene regarding client C's aggressive outburst/aggression.</p> <p>-"Vacating. Staff should be aware of [client C's] whereabouts at all times. In inclement weather, keep protective clothing for staff and [client C] near the door so that it is easily available if [client C] exits the home. If [client C] elopes from staff, keep her in sight and calmly request that she make a positive choice</p>			

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	<p>and return to the home or vehicle with you. (3.) (sic) If [client C] responds, thank her for returning and continue with the activity or outing that was going on previous to her elopement. If [client C] appears upset ask her if she wants to talk about what is bothering her or if she needs time to be alone to calm herself down. (4.) If she refuses to return, calmly request again that she return to the location that she eloped from. Continue to follow her but do not make a big deal out of it, do not discuss the situation further. Give [client C] time to think about it (15 minutes) while you are following her and monitoring for safety. (5.) If [client C] refuses after 15 minutes to return, offer her another opportunity to return, if she continues to refuse after this offer, contact the PD or PD on-call for further instructions." The review did not indicate documentation of when staff should utilize police or other emergency service personnel to intervene regarding client C's elopement behaviors.</p> <p>Client C's 5/4/15 "Risk Management Plan" indicated client C did not "associate consequences with actions, [client C] receives 24/7 (twenty-four hours and day seven days a week) staff support and supervision...[client C] is impulsive and can be defiant...[client C] will not be unattended in the</p>			

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W 0159 Bldg. 00	<p>community...law enforcement may get involved due to elopement."</p> <p>An interview was conducted with PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) on 6/25/15 at 10:15 AM. PD/QIDP indicated client C's BSP should include specific instructions or interventions regarding when staff should utilize police or other emergency service personnel to intervene regarding client C's SIB, physical aggression or elopement behaviors. PD/QIDP indicated client C's police involvement component was indicated on client C's Risk Plan.</p> <p>This federal tag relates to complaint #IN00176248.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 3 of 3 sampled clients (clients A, B, and C), the QIDP (Qualified Intellectual Disabilities Professional) failed to integrate, coordinate, and monitor clients A, B, and C's active treatment programs.</p>	W 0159	<p>1.Please refer to W149 2.Please refer to W227 3.Please refer to W240 4.Please refer to W249 5.Please refer toW289 6. QIDP will be retrained on review of QIDP responsibilities related to recognizing behavioral</p>	07/17/2015

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	<p>Findings include:</p> <ol style="list-style-type: none"> <li>The QIDP failed to ensure implementation of the agency's policy and procedure to prohibit abuse, neglect, mistreatment, and/or exploitation of clients A, B, and C. The QIDP failed to protect client A from elopement after a history of elopement behaviors was identified which resulted in sexual assault, substance abuse, and personal injury. The QIDP failed to ensure staff were available and competent to supervise and implement client A, B, and C's ISP (Individual Support Plan), BSP (Behavior Support Plan), and Risk Plan. The QIDP failed to develop further safeguards and corrective measures regarding client A, B, and C's continued elopement behaviors for 3 of 3 sampled clients (clients A, B, and C). Please refer to W149.</li> <li>The QIDP failed to integrate, coordinate, and monitor to ensure client A, B, and C's ISPs (Individual Support Plan) and BSPs (Behavior Support Plan) included specific interventions to address client A, B, and C's elopement behaviors and teach personal safety. Please refer to W227.</li> <li>The QIDP failed to integrate,</li> </ol>		<p>and medical patterns and ensuring effective corrective action is taken to prevent future occurrences. Training will include ensuring that IDTs are held as soon as possible after an incident that requires immediate protective measures to be put in place. The IDT should determine if the immediate protective measures are appropriate to continue and if any changes need to be made. QIDP will update and revise ISP, RMAP, Behavior Support Plan, etc. as needed. QIDP will ensure all staff are trained on any updates to any of the above documents. QIDP retraining will include ensuring that documentation of IDT meetings and topics discussed is completed and available in client charts for review.</p> <p>Area Director will meet with QIDP weekly for 4 weeks to review any incidents that have occurred in the home, the effectiveness of protective measures that have been put into place and recommendations from any IDT meetings that have occurred. After the first 4 weeks, the Area Director will meet with the QIDP at least twice monthly to review any incidents that have occurred in the home, the effectiveness of protective measures that have been put into place and recommendations from any IDT meetings that have occurred. After 8 weeks the Area Director the frequency of ongoing</p>	
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	<p>coordinate, and monitor to ensure client A, B, and C's BSP (Behavior Support Plan) indicated when facility staff should contact emergency service personnel and/or described interventions to promote independence regarding client A, B, and C's elopement and/or physical aggression behavior incidents. Please refer to W240.</p> <p>4. The QIDP failed to integrate, coordinate, and monitor to use formal and informal opportunities to implement client A, B, and C's ISP (Individual Support Plan) and BSP (Behavior Support Plan) when opportunities existed and failed to use consistent approaches during physically aggressive behaviors and elopement behaviors. Please refer to W249.</p> <p>5. The QIDP failed to integrate, coordinate, and monitor interventions employed for behavior and to have a written description in client A's plan for physical behavioral interventions/Physical Intervention Alternatives (PIA) which were used for client A. Please refer to W289.</p> <p>This federal tag relates to complaint #IN00176248.</p> <p>9-3-3(a)</p>		meetings.	

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W 0186  Bldg. 00	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, interview, and record review, for 3 of 3 sampled clients (A, B, and C) and 5 additional clients (D, E, F, G and H), the facility failed to ensure sufficient staff were present to supervise clients based on their identified behaviors of elopement (AWOL Absent Without Leave) in the group home.</p> <p>Findings include:</p> <p>On 6/23/15 at 3:50pm, clients B, C, D, E, F, G, and H arrived home from the workshop at 3:30 PM. At 3:50pm, an interview was conducted with the House Manager (HM) who indicated there were supposed to be 2 staff working the evening shift daily and 1 staff working during the overnight periods. From 3:50pm until 4:25pm, two (2) staff were on duty with seven (7) clients (clients B, C, D, E, F, G, and H). From 4:25pm until 5:45pm, three (3) facility staff were on duty with seven clients in the group home. Client A was not in the group</p>	W 0186	<p>A 1:1 staffing protocol has been developed for Client A and will be immediately implemented upon her return to the group home for client protections. Each staff responsible for the implementation of the 1:1 protocol will be trained prior to assuming responsibility. At this point Client A has not returned to the Group home so this 1:1 protocol has not been put into place.</p> <p>Home Manager, QIDP and Area Director have met to review the current staffing schedule and identify the staffing needs of the home. It has been identified that the staffing ratio in the home will consist of a minimum of 2 staff during waking hours, so that if one consumer elopes one staff is able to follow that consumer while the other staff can stay with the remaining clients and call the Home Manager, QIDP or emergency personnel for assistance as needed. At this time, increased staffing during overnight hours has not been a</p>	07/17/2015	

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	<p>home.</p> <p>On 6/24/15 from 6:30am until 7:15am, clients B, C, D, E, F, G, and H were at the group home with one (1) facility staff and the House Manager (HM). From 7:15am until 8:10am, two (2) facility staff and the House Manager were at the group home with seven clients.</p> <p>On 6/25/15 from 6:50am until 7:00am, one (1) facility staff and the House Manager was at the group home with seven clients. From 7:00am until 7:50am, two (2) facility staff and the House Manager was at the group home with seven clients.</p> <p>On 6/26/15 from 6:05am until 7:18am, one (1) facility staff was at the group home with seven clients. From 7:18am until 7:25am, two (2) facility staff were at the group home with seven clients.</p> <p>On 6/24/15 at 1:25pm, a review of the facility's staffing schedule was conducted. The schedule indicated for the period from 6/14/15 through 6/27/15: for Monday through Friday, the morning (day shift) for two (2) shift staff worked from 7:00 AM until 3:00 PM, in the evening two (2) shift staff worked from 2:00 PM to 10:00 PM, and one (1) shift staff worked from 10:00 PM to 8:30 AM.</p>		<p>determined need on an ongoing basis, however if a situation occurs where there is an identified risk of the potential for elopement based on observations or expressed needs of the consumers or outside parties, including Day Service providers, therapists, parents/guardians, etc., additional staffing will be assigned for overnight hours. Need for ongoing additional overnight staffing will be assessed by QIDP and Area Director on a daily basis.</p> <p>When the consumers are scheduled to be out of the house for community activities, additional staffing will be assigned to accompany consumers so that if any elopements are attempted one staff will be able to follow the eloping consumer and implement Behavior Plan strategies and the other staff can remain with the other consumers. Since there are two consumers remaining in the home that have identified target behaviors of elopement, each will be provided with 1:1 staffing in the community in case elopements are attempted.</p> <p>The Home Manager and QIDP will meet minimum of weekly to review the scheduled community activities and adjust the schedule accordingly to assign additional staffing to ensure all consumers health and safety needs are being</p>	

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	<p>For the weekend one (1) facility staff for the period from 7:00 AM until 3:00 PM and one (1) facility staff from 8:00 AM until 3:00 PM, two facility staff from 2:00 PM until 10:00 PM, and one facility staff from 10:00 PM until 8:30 AM.</p> <p>On 6/29/15 at 5:30pm, a review of the facility's staffing schedule was conducted. The schedule indicated for the week of 6/29/15 in the morning (day shift) two (2) shift staff worked from 7:00 AM until 3:00 PM, in the evening two (2) shift staff worked from 2:00 PM to 10:00 PM, and one (1) shift staff worked from 10:00 PM to 8:30 AM.</p> <p>On 6/24/15 at 11:00am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed. The review indicated the following for clients A, B, and C:</p> <p>-A 6/18/15 BDDS report for an incident on 6/17/15 at 6:00pm indicated "On Wednesday, June 17, 2015 at 5:52pm" the Residential Manager (RM) notified the Qualified Intellectual Disabilities Professional/Program Director (QIDP/PD) that client A "had eloped from her Indiana Mentor Group Home. Of the two staff on shift, one staff was on an outing with other clients in the Group</p>		<p>met. All direct care staff have received training on necessary staffing ratios while in the group home and out on community outings. Training included that if any situation occur that these staffing ratios are not able to be met for some reason (one client elopes, a staff is late to a shift, etc.) they are to notify the Home Manager and/or QIDP immediately so that the Home Manager and/or QIDP can arrange for additional staffing support as soon as possible so that consumers health and safety needs are being met. Another group home is located nearby that can be used as an option for additional staffing support quickly in the event that a consumers elopes or staffing situation occurs that prevents the assigned staffing ratios from being implemented until the Home Manager and/or QIDP is able to secure additional staffing or get to the site themselves.</p> <p>Management observations will be completed a minimum of daily for 6 weeks to ensure that assigned staffing ratios are being provided and Behavior Support plans are being implemented as written. Identified managers that are able to complete daily observations include QIDP, Area Director, Regional Director, Quality Assurance Manager, Behavior Specialist and any other QIDP or Area Directors that have been</p>	

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	<p>Home and one was behind with the client that eloped (client A) and a few other clients." The report indicated client A eloped and "the one staff member (at the group home) walked to the end of the driveway and watched the client while talking to [the RM]...eventually reporting she could no longer see the client." The report indicated client A arrived at a different all male group home "approximately a 1/2 (half) hour (sic) later; staff was unable to ascertain how she got there...[client A] refused to go back to her Group Home. Police were called and when they arrived, they told the client she had the right to elope and because she was not a threat of harm to herself or those around her, they would leave. Prior to leaving, they (the Police) told [client A] she should go back home which was approximately 7:00pm. [Client A] got into the Group Home van, cursing at staff, stating she was going to run away again as soon as she got there (back to her Group Home). [Client A] arrived to (her Group Home) shortly before 8:00pm, still cursing at staff, laughing hysterically, and threatening to run. Both the staff on shift kept [client A] within their sight because of [client A's] threats." The report indicated client A took her 8:00pm medications and "Afterwards, [client A] told the staff to stop following her and then she started to</p>		<p>trained on the needs of the home. Home Managers are able to complete additional observations to ensure that assigned staffing ratios are being provided and Behavior Support plans are being implemented as written but Home Manager observations will not replace daily upper management observations. Any of the above designated managers that are completing observations will complete an observation checklist that designates if appropriate staffing levels are being maintained, if Behavior plans are being implemented as written and will review that documentation is being completed. If any issues are noted, the Management observer will immediately notify the assigned homes QIDP or Area Director so that immediate corrective measures can be put into place. The Area Director or Regional Director will review all observation checklists to ensure that appropriate staffing levels are being maintained, Behavior plans are being implemented as written and will review that documentation is being completed. After the 6 weeks, a team of the QIDP, Area Director, Regional Director and Quality assurance manager will meet to review observation results and develop plan for frequency that ongoing upper management observations will occur.</p>	

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	<p>use closed fist punches to one staff member whom was blocking [client A's] way to an exit door. The staff member attempted to use the one arm hold...The second staff was attempting to stop two other clients whom were threatening to elope at the same time. The first staff member released [client A's] arm and [client A] ran out of the home. At that time the [Residential Manager (RM)] was already parked in her car in front of the [Group Home] reporting to the [PD] that [client A] was threatening to leave when [client A] did just that...The [RM] turned her car on and followed [client A] down the street and into the apartment complex nearby where [the RM] lost sight of [client A]." The report indicated the RM and the PD "drove around for a few minutes," could not locate client A, and called the Police. The report indicated "the time [client A] eloped was approximately 8:37pm. At this time, [client A] has still not been located by the Police nor Mentor staff assisting in looking for [client A]...."</p> <p>-A 4/29/15 BDDS report for an incident on 4/28/15 at 5:10pm indicated client B returned from a psychiatric appointment "agitated that she was having a med (medication) increase. Shortly later, she was prompted by staff to turn her music down." The report indicated client B</p>		<p>Client A, B and C Behavior plans, Risk plans and ISP have all been updated to reflect what level of supervision above clients need while in the group home, on community outings and in the event that an elopement occurs and after a client is returned home after an elopement behavior occurs.</p> <p>QIDP will receive retraining to include ensuring that supervision levels of all consumers are identified in their individual ISP, BSP and risk plans. Training will also include ensuring that Home Manger and QIDP are meeting weekly to review the scheduled community activities and adjust the schedule accordingly to assign additional staffing to ensure all consumers health and safety needs are being met.</p> <p>The Area Director or Regional Director will review all observation checklists to ensure that appropriate staffing levels are being maintained, Behavior plans are being implemented as written and will review that documentation is being completed. After the 6 weeks, a team of the QIDP, Area Director, Regional Director and Quality assurance manager will meet to review observation results and develop plan for frequency that ongoing upper management observations will occur.</p>		

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	<p>"responded by flipping the living room table and charging the staff." The report indicated client B "eloped out the front door where staff watched her from the front porch. Staff watched [client B] go to the neighbor's house on both sides of the group home, knocking on their doors, staff had client in sight from the group home front porch. Finally, a person answered the door to one of the houses and [client B] went inside where staff lost sight of her. At that time, [the PD/QIDP] was notified. Client returned to the group home site within 2 minutes stating she called her sister." The report indicated client B told the PD/QIDP that the staff on duty at the group home had "pushed [client B] and that was why she had to go call her sister...Plan to resolve...Clients' plan to be changed to include that of Elopement."</p> <p>-A 5/15/15 BDDS report for an incident on 5/14/15 at 5:50 PM indicated, "At 5:50 PM, the PD (Program Director) was notified that [client C] had left the premises of the group home walking on the sidewalk. [The PD] informed the staff they would arrive to (sic) the site in 25-30 minutes to assist. Staff reported they stayed with the [client C], walking down the street sidewalk of the group home, continuing to follow and attempt(ing) to redirect [client C] when</p>			

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	<p>[client C] turned onto [road] a busy street. At that time, [client C] stepped off the sidewalk and into the street, back and forth numerous times in an unsafe manner. The staff was able to guide [client C] back onto the sidewalk each time, however, felt that [client C] was attempting to harm themselves (sic) so the staff member called 911. Police intercepted the client when she was walking on [street] near [street]. Police called the group home, requesting the second staff member, working that night and attending to the other clients, pick [client C] and the first staff member up from their position. The second staff member gathered up the clients she was caring for, placed them into the van and picked up the did so (sic). [PD #1] arrived to (sic) the site at 6:20 PM to find that [client C] had been brought back to the site by staff who picked her up from police and the first staff member's care."</p> <p>-A 4/13/15 BDDS report for an incident on 4/12/15 at 10:45 PM indicated, "[HM (Home Manager)] called (the) on-call [PD] to report that [client C] had walked away from the group home. Staff called 911 for additional supports and when staff hung up the phone, [client C] was back at the group home. [Client C] was out of staff's sight for 2 minutes before returning back to (the) group home."</p>			

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	<p>-A 3/7/15 BDDS report indicated, "At 6:45 PM, [PD] was notified by staff that 911 had been called from the group home due to [client C's] physical aggression toward staff. Prior to the 911 call, staff prompted [client C] to pick up the piles of clothes all around her bed and start washing them or hanging them up if they were clean. [Client C] started to yell loudly that she was not going to clean up her room. The staff then started picking up the clothes that smelled of urine and started to walk out of her room to the washing machine. At that time and just as the staff member was exiting [client C's] room, [client C] put both of her hands on the staff, proceeded to punch her with both closed fists multiple times. The second staff then ran down the hall to [client B's] room and attempted to put herself in between [client C] and the staff member getting hit but [client C] kept reaching around her and punching the first staff member whom was on the bedroom floor. The second staff member continued to use two hand blocks to keep both staff safe. Sometime during this altercation another client in the home proceeded to call 911 of their own accord. [Client C] continued physical aggression until shortly before the police showed up to the group home about 5 minutes after she hit staff the first time.</p>			
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	<p>[Client C] was questioned by the police, told to stop her behavior and the police left. As soon as they left, [client C] started threatening to harm herself, yelling and pacing the home without ceasing for 20 minutes straight. During those 20 minutes she was reaching for items, saying she was going to cut herself. At that time, staff felt they could not keep themselves nor [client C's] housemates safe, so staff called 911 again. Upon the arrival of police for the second time, [client C] was taken to [hospital]."</p> <p>Client A's record was reviewed on 6/24/15 at 11:50am. -Client A's 5/4/15 ISP indicated client A had "targeted behaviors" which included: Panic Attacks, Inappropriate interaction with males, and vacating (elopement) behaviors. Client A's ISP indicated she had elopement behaviors 9/2/14 when client A "was discovered to have eloped from her group home. She was found on 9/3/14 at 8:15am at a [name of group home] that of her alleged boyfriend... [Client A] had consensual sex with her alleged boyfriend and also went to sleep next to him during the night...9/24/14 [client A] was found under her bedroom covers with two other clients whom alleged that sexual misconduct had taken place in the form of her (female)</p>			

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	<p>housemate touching her in the breast and vagina area. The allegation could not be substantiated...10/18/14 at 8:00pm, [client A] successfully eloped from the group home and was later found at her (different) boyfriend's [name of group home] at 8:28pm. She willingly transported back to her group home but threatened to elope again...2/17/15 stayed in a hotel all night and day with her (different) boyfriend while on a home visit in [name of city]...." Client A's ISP indicated she required twenty-four hour a day staff supervision.</p> <p>-Client A's 10/18/14, 9/24/14, and 9/2/14 IDT (Interdisciplinary Team) meeting notes indicated "1:1 (One on One) staff supervision" was implemented after each incident of elopement and did not indicate when the one on one staff supervision was changed.</p> <p>-Client A's 5/4/2015 "Risk Management Assessment and Plan" indicated client A "Presents a risk" for the following areas of assessment: "Wears glasses...Some balance issues due to her left leg being somewhat shorter than her right, walks with a limp...slight weakness in her hand...is not able to administer medications independently...panic attacks...(does not) associate consequences with actions [client A] has</p>			

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	<p>a history of inappropriate interactions with males as well as placing herself in potentially dangerous situations in her interactions with males. Would benefit from 24/7 supervision to ensure her health and safety and general welfare... (does not) inform support person (the staff) of plans when leaving home area. [Client A] has history of elopement...would readily get into a car with a man she does not know if he paid attention to her...(does not) exhibit socially accepted behaviors in public... (does not) have ability to remain alone in any environment. [Client A] lacks the ability to do this independently...Would not likely defend herself...may not be able to recognize what is considered abuse and therefore not report appropriately...[Client A] needs assistance with her finances...has a history of cutting herself...[Client A] requires 24 hour awake supervision."</p> <p>-Client A's 2/2014 BSP indicated identified targeted behaviors of Panic Attack, Inappropriate with males, and vacating (elopement). Client A's BSP indicated "Vacating...Staff should be aware of [client A's] whereabouts at all times...If [client A] elopes from staff, keep her in sight and calmly request that she make a positive choice, and return to the home or vehicle with you...If [client</p>			

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	<p>A] appears upset ask her if she wants to talk about what is bothering her, or if she needs time to be alone to calm herself down. If she refuses to return, calmly request again that she return to the location that she eloped from. Continue to follow her, but do not make a big deal out of it, do not discuss the situation further. Give [client A] time to think about it, 15 min. (minutes), while you are following her and monitoring for safety. If [client A] refuses after 15 minutes to return, offer her another opportunity to return, if she continues to refuse after this offer, contact the PD (Program Director) or PD (Program Director) on call for further instruction, do not inform [client A] that you are contacting the PD, do not make a fuss or a big deal about contacting the PD. If [client A's] elopement has put her in a potentially dangerous situation in a high traffic area, implement least restrictive agency approved physical intervention (PIA) to maintain safety. If possible a staff member that is not actively intervening with [client A] contact the PD...." Client A's plans did not include what level of staff supervision staff were to provide.</p> <p>On 6/24/15 at 2:40pm and on 6/25/15 at 8:25am, client B's record was reviewed. Client B's 9/2014 BSP for the group home staff to use did not include</p>			

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	<p>elopement behaviors. An additional non approved HRC (Human Rights Committee) 4/28/15 BSP and 4/28/15 ISP included elopement behavior on the list of targeted behaviors and did not include interventions staff should use and did not include a written description of client B's elopement behavior. Client B's plans did not include what level of staff supervision staff were to provide.</p> <p>Client C's record was reviewed on 6/24/15 at 2:00 PM. Client C's 9/20/14 BSP indicated the following and did not include what level of staff supervision staff were to provide.</p> <p>-"Response Measures- SIB. If staff observed [client C] engaging in SIB, request that she stop the behavior. If she stops the SIB, thank her. Request that [client C] then engage in a leisure activity or utilize her coloring sheets. If [client C] would like to talk with staff, staff should allow [client C] time to discuss her concern or frustration. If [Client C] continues the behavior after being requested to stop and the behavior is not causing her physical harm, i.e. scratching at skin without breaking skin, pinching herself etc., ignore the behavior but not [client C]. Continue to monitor [client C] for the SIB to escalate. Request that [client C] engage in another activity with</p>			

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	<p>you. It is important that she engage with staff at this time. Staff should color with her, go for a walk, play a game etc. with [client C]. If steps above are unsuccessful and the SIB is a threat to [client C's] safety, use the least amount of agency approved physical intervention (PIA) to stop the SIB. Inform the PD (or) PD on-call." The review did not indicate documentation of when staff should utilize police or other emergency service personnel to intervene regarding client C's SIB.</p> <p>-"Aggressive Outburst: (1.) Immediately request that [client C] cease the behavior. Request that she calm herself down. Inform [client C] that once she is calm, you will spend time with her talking about what is upsetting her. Allow her to tell you what she is upset about. All you need to do is listen to her. When she has finished encourage her and engage with her in an activity such as coloring, exercise or playing a game; (2.) If the behavior continues and is directed toward other person in the environment, ask them to leave the area for their own safety. Prompt [client C] to engage in a calming activity; (3.) Do not touch [client C] but tell her she will be okay, ask her what you can do to assist her with calming down; (4.) If [client C] is unable or unwilling to calm down or if the</p>			

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	<p>outburst is a danger to self or others proceed to step 5; (5.) Direct [client C] to discontinue the behavior immediately; (6.) If the aggressive outburst continues and is a risk of injury to self or others use the agency approved minimum amount of physical guidance necessary to stop the behavior. Use the techniques taught by Indiana Mentor (PIA)." The review did not indicate documentation of when staff should utilize police or other emergency service personnel to intervene regarding client C's aggressive outburst/aggression.</p> <p>- "Vacating. Staff should be aware of [client C's] whereabouts at all times. In inclement weather, keep protective clothing for staff and [client C] near the door so that it is easily available if [client C] exits the home. If [client C] elopes from staff, keep her in sight and calmly request that she make a positive choice and return to the home or vehicle with you. (3.) (sic) If [client C] responds, thank her for returning and continue with the activity or outing that was going on previous to her elopement. If [client C] appears upset ask her if she wants to talk about what is bothering her or if she needs time to be alone to calm herself down. (4.) If she refuses to return, calmly request again that she return to the location that she eloped from. Continue to follow her but do not make a big deal</p>			

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	<p>out of it, do not discuss the situation further. Give [client C] time to think about it (15 minutes) while you are following her and monitoring for safety. (5.) If [client C] refuses after 15 minutes to return, offer her another opportunity to return, if she continues to refuse after this offer, contact the PD or PD on-call for further instructions." The review did not indicate documentation of when staff should utilize police or other emergency service personnel to intervene regarding client C's elopement behaviors.</p> <p>Client C's 5/4/15 "Risk Management Plan" indicated client C did not "associate consequences with actions, [client C] receives 24/7 (twenty-four hours and day seven days a week) staff support and supervision...[client C] is impulsive and can be defiant...[client C] will not be unattended in the community...law enforcement may get involved due to elopement."</p> <p>An interview was conducted with PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) on 6/25/15 at 10:15 AM. The PD/QIDP indicated clients A, B, and C should be supervised by facility staff twenty-four hours a day seven days a week. The PD/QIDP indicated client A, B, and C's plans did not include what level of staff</p>			

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W 0191 Bldg. 00	<p>supervision clients A, B, and C needed.</p> <p>On 6/25/15 at 10:15 AM, an interview with the AD and the PD/QIDP was conducted. The AD indicated the group home was staffed for one (1) staff on the overnight shift, two (2) staff during the day shift, and two (2) staff during the evenings. The AD indicated the House Manager was at the group home during different times each day. When asked if the staff schedule met the identified needs of the clients living in the group home, the AD stated "It is what we are reimbursed for."</p> <p>This federal tag relates to complaint #IN00176248.</p> <p>9-3-3(a)</p> <p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs.</p> <p>Based on observation, record review, and interview, for 1 of 3 sampled clients (client A), the facility failed to ensure group home staff were trained and competent to provide for client A's behavioral needs.</p>	W 0191	All direct care staff have received training on necessary staffing ratios while in the group home and out on community outings. Training included that if any situation occur that these staffing ratios are not able to be met for some reason (one client elopes, a staff is late to a shift, etc.) they	07/17/2015

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	<p>Findings include:</p> <p>On 6/23/15 from 3:20pm until 5:40pm and on 6/24/15 from 6:30am until 8:10am, observations and interviews were completed at the group home and client A was not present. During both observation periods GHS (Group Home Staff) #1, GHS #2, GHS #3, and the House Manager indicated no staff training and/or re training had been completed for the previous 3 months.</p> <p>On 6/24/15 at 11:00am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed. The review indicated the following for client A:</p> <p>-A 6/18/15 BDDS report for an incident on 6/17/15 at 6:00pm indicated "On Wednesday, June 17, 2015 at 5:52pm" the Residential Manager (RM) notified the Qualified Intellectual Disabilities Professional/Program Director (QIDP/PD) that client A "had eloped from her Indiana Mentor Group Home. Of the two staff on shift, one staff was on an outing with other clients in the Group Home and one was behind with the client that eloped (client A) and a few other clients." The report indicated client A eloped and "the one staff member (at the group home) walked to the end of the</p>		<p>are to notify the Home Manager and/or QIDP immediately so that the Home Manager and/or QIDP can arrange for additional staffing support as soon as possible so that consumers health and safety needs are being met.</p> <p>All direct care staff have also received training on updates to Client A, B and C revised behavior plans, specifically focusing on interventions to address and prevent threats and/or attempts to elope from the group home as well as any updated to all other consumers Behavior Support Plans. Training also included any new goals/objectives in the ISP and/or BSP and interventions for addressing/preventing any of the consumers identified targeted behaviors.</p> <p>QIDP and Home Manager have received training that includes ensuring that all staff are trained on any current and ongoing updates to consumers BSP, ISP and Risk plans as immediately as possible after changes have been made. Training also included ensuring that any staff working in the home have documentation of client specific training (including ISP, BSP and Risk plans) available for review. At this time all staff trainings are being kept on site in a binder along with the Upper management observation forms.</p>		

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	<p>driveway and watched the client while talking to [the RM]...eventually reporting she could no longer see the client." The report indicated client A arrived at a different all male group home "approximately a 1/2 (half) hour (sic) later; staff was unable to ascertain how she got there...[client A] refused to go back to her Group Home. Police were called and when they arrived, they told the client she had the right to elope and because she was not a threat of harm to herself or those around her, they would leave. Prior to leaving, they (the Police) told [client A] she should go back home which was approximately 7:00pm. [Client A] got into the Group Home van, cursing at staff, stating she was going to run away again as soon as she got there (back to her Group Home). [Client A] arrived to (her Group Home) shortly before 8:00pm, still cursing at staff, laughing hysterically, and threatening to run. Both the staff on shift kept [client A] within their sight because of [client A's] threats." The report indicated client A took her 8:00pm medications and "Afterwards, [client A] told the staff to stop following her and then she started to use closed fist punches to one staff member whom was blocking [client A's] way to an exit door. The staff member attempted to use the one arm hold...The second staff was attempting to stop two</p>		<p>The Area Director and/or Regional Director will review training records for all staff working in the home a minimum of twice weekly for 6 weeks to ensure that there is documentation present for all staff showing that they were trained on staffing ratios and updates to Behavior Support Plans.</p> <p>A section for documentation of staff training has been added to all consumers Behavior Support plans so that documentation of staff training on that specific plan is included with the BSP and available for review when reviewing individual BSPs.</p> <p>Ongoing, QIDP will ensure that staff training is present for review for any updates and/or changes to consumers BSP and/or ISPs as they occur. QIDP will ensure that staff training is available for review at any time requested.</p>	

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	<p>other clients whom were threatening to elope at the same time. The first staff member released [client A's] arm and [client A] ran out of the home. At that time the [Residential Manager (RM)] was already parked in her car in front of the [Group Home] reporting to the [PD (Program Director)] that [client A] was threatening to leave when [client A] did just that...The [RM] turned her car on and followed [client A] down the street and into the apartment complex nearby where [the RM] lost sight of [client A]." The report indicated the RM and the PD "drove around for a few minutes," could not locate client A, and called the Police. The report indicated "the time [client A] eloped was approximately 8:37pm. At this time, [client A] has still not been located by the Police nor Mentor staff assisting in looking for [client A]...."</p> <p>Summary of Internal Investigative Report dated 6/22/15 indicated the following: -"Brief Summary of incident: On 6/17/15 at 5:52pm, [client A] eloped from the home, was located by staff and returned to the group home. [Client A] eloped a second time after 8pm and was unable to be located. A report was filed with the [Name of Police Agency]."</p> <p>-The investigation indicated those interviewed were three direct care staff,</p>			

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	<p>the Residential Manager, and the Program Director. The investigation was not thorough in that the investigation did not indicate completed interviews with clients who were present at the time of each elopement.</p> <p>- "Background of client and their placement...(Client A's diagnoses included but were not limited to:) Mild Intellectual Disability, Traumatic Brain Injury with behavior disturbance, ADHD (Attention Deficit Hyperactivity Disorder), Seizure DO (Disorder)... [Client A's] history of elopement started prior to her placement at Indiana Mentor, [client A's] ISP and Risk Plan states she experiences Panic Attacks. On 9/2/14 [client A] was missing for over 12 hours and was found in the bed of a client after entering his home through a window without staff knowledge...[Client A's] mother became her legal guardian on 7/21/14."</p> <p>- "Interview" with the RM indicated she followed client A in her car during client A's second elopement (6/17/15 at 8:37pm) "...when [client A] reached [name of street] [Client A] attempted to dart into traffic so [the RM] used her car to block [client A] from getting hit by other cars as [the RM] pleaded for [client A] to get in [the RM's] car." The RM</p>			

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	<p>indicated she followed client A until she entered the apartment complex where the RM lost sight of client A.</p> <p>-"Interview" with Group Home Staff (GHS) #1 indicated she had picked up client A from day services, returned to the group home, and client A had called her mother and family members without making contact on the telephone. GHS #1 indicated client A became upset and "she [client A] was leaving and ran out the door...[GHS #1] was by herself with clients...she was able to see [client A] from the end of the driveway until [client A] ducked behind the school...[GHS #1] received call from the [RM] to meet at [the second group home]...[client A] was out of control (when GHS #1 arrived at the second group home)...[GHS #1] said [client A] finally agreed to get in the van, but said she was going to run away again when she got home. [GHS #1] said on the way home [client A] was asked to show them (the staff) where [client A] had knocked on the door and got a ride to [the second group home]. [GHS #1] said [client A] said she knocked on the door, cried, saying she was lost, and needed a ride to [name of second group home]...."</p> <p>-"Interview" with GHS #2 indicated she was out shopping with client E, returned in the van to the group home to find GHS</p>			

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	<p>#1 standing in the driveway looking for client A. GHS #2 "said when [client A] returned home she was treated like a rock star by her housemates. [GHS #2] said [client A] was being congratulated, high fived, and generally encouraged for running away. [GHS #2] said there was a lot of commotion and the noise level was high...[Client A] continued to threaten to leave. Attempts to calm [client A] were not successful. [GHS #2] said at about 8:30pm, [client A] ran out the front door and all her housemates ran to the front of the house and cheered her on."</p> <p>-"Interview" with the PD (Program Director) indicated "...On 6/22/15 she received a call from [GHS #7] a [substitute staff at the group home] the morning of 6/20/15 (Saturday). [PD] said [GHS #7] informed her that the police had [client A] at 34th (Street) and Meridian St. and was being taken to [Name of Hospital] for evaluation. [PD] said she met [client A] at the emergency room. [PD] said she had only a few minutes alone with [client A] before [client A's] mother arrived. [PD] said [client A] stated she made \$60.00 for sex, but then was forced to take drugs and was passed around for sex, which she did not like. [PD] said [client A's] mother took [client A] home following the forensic evaluation. [PD] said she has applied for</p>			

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	<p>the Project Lifesaver (electronic monitoring device), which would not be available for up to two months due to availability."</p> <p>-"Interview" with client A's mother/guardian indicated client A's mother/guardian had been driving to Indianapolis from [name of city] in an attempt to locate client A on the street. Client A's mother/guardian indicated she was tracing telephone calls made by client A when client A called family members out of town and had traced client A who was using other people's cell phones which she had borrowed on the street and a pay phone at a bus stop. Client A's mother/guardian indicated she was at the hospital with client A on 6/20/15 after being notified that client A had been found. Client A's mother/guardian indicated client A "told her she (client A) did make \$60.00 from a man who then started pimping [client A] out...(client A) was forced to consume drugs and was passed from person to person including a women for sex...when [client A] told them to stop she was told to get her things and get out...(client A) tested positive for cocaine, opiates, and THC (Tetrahydrocannabinol, a chemical responsible for most of marijuana's psychological effects)...(client A) is experiencing pain with rectal and vaginal</p>			

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	<p>bleeding...(Client A) is having panic attacks and nightmares...." Client A's mother/guardian stated "she intends to keep [client A] home until the Project Life Saver can be put into place."</p> <p>-"Conclusion" indicated client A eloped twice on the evening of 6/17/15. Evidence supports physical intervention was not used in order to keep client A from leaving the group home. The investigation was not thorough in that it did not document witness statements from other clients present in the home and during both elopements of client A. The investigation did not indicate recommendations and corrective actions to protect client A and to protect other clients from their identified behaviors. The investigation did not indicate documentation of staff implementing client A's BSP, ISP, or the effectiveness of PIA (Physical Intervention Alternatives) techniques to prevent the incident from escalating from client A's elopement behaviors.</p> <p>Client A's 6/20/15 Hospital Emergency Room Record was reviewed on 6/24/15 at 8:30am. The hospital record "Emergency Room" documentation by the physician indicated "Pt. (Patient) reports that she ran away from group home 3 days ago. She reports she met a</p>			

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	<p>man who offered her money, made her smoke spice and marijuana, snorted cocaine. She reports she was sexually assaulted by upward of 7 different men over that time on separate occasions. She reports vaginal, anal, and oral penetration...inflamed skin external genitalia...Assessment: Sexual Assault, medically stable...+ (positive) for cocaine / opiates...pelvic done/evidence collected...given counseling sources... (signed by the physician)." The 6/20/15 "ER Triage Chief Complaint...Drug Abuse, possible Sexual Assault of adult." Client A's 6/20/15 "EMS (Emergency Medical Services) Incident" document indicated "9-1-1 dispatched for injured person...found 19 yo/w/f (year old/white/female) ambulatory on scene with [Police]. [Police] stated that pt. (patient) was found laying on the ground in the doorway of a hallway to an apartment building with many bystanders around. [Client A] told [Police] that she walked away from her group home (and) she stays there due to a previous brain injury. On June 17th and (sic) was picked up by a couple of guys. According to [Police], after that the men gave her crack cocaine, pt. states she snorted and smoked it and (they) physically sexually assaulted her. Pt. claims to have not slept since Tuesday and last used crack cocaine about 20</p>			

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	<p>minutes prior to being found by [Police]. Her only complaint was that her face was numb, she was having tingling in her upper extremities, and she was sleepy from having not slept since Tuesday. [Police] notified representatives from her group home enroute to [name of hospital]. [Client A] started to feel nauseous but did not vomit until we started to pull into the ambulance bay at [name of hospital]...."</p> <p>Confidential Interview (CI) #1 stated on 6/20/15 client A was "filthy dirty," was not wearing client A's personal clothing, was not wearing underwear, was not wearing a bra, and had injuries to her face, chest, and genitalia.</p> <p>CI #2 stated client A "does not understand consent and could not give consent." CI #2 stated client A had "told (CI #2) that she was passed around from man to man and some women" for sex. CI #2 indicated client A told her she left the group home the second time on 6/17/15, hitchhiked to [name of neighborhood], walked the streets, met the man who told client A she was pretty, and that he could show client A how to make money. CI #2 indicated client A told CI #2 that the man had sex with client A multiple times, passed her to other men and women for sex to</p>			

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	<p>exchange for money, lived on the streets of Indianapolis, consumed cocaine, marijuana, and opiates. CI #2 indicated on Saturday, 6/20/15 client A said she was asked to step outside an apartment during a visit to a new location with the unknown man, client A stepped outside the apartment in the doorway, sat down, fell asleep, and woke up with the Police Officers looking at her.</p> <p>Client A's record was reviewed on 6/24/15 at 11:50am.</p> <p>-Client A's 5/4/15 ISP indicated client A had "targeted behaviors" which included: Panic Attacks, Inappropriate interaction with males, and vacating (elopement) behaviors. Client A's ISP indicated she had elopement behaviors 9/2/14 when client A "was discovered to have eloped from her group home. She was found on 9/3/14 at 8:15am at a [name of group home] that of her alleged boyfriend... [Client A] had consensual sex with her alleged boyfriend and also went to sleep next to him during the night...9/24/14 [client A] was found under her bedroom covers with two other clients whom alleged that sexual misconduct had taken place in the form of her (female) housemate touching her in the breast and vagina area. The allegation could not be substantiated...10/18/14 at 8:00pm, [client A] successfully eloped from the</p>			

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	<p>group home and was later found at her (different) boyfriend's [name of group home] at 8:28pm. She willingly transported back to her group home but threatened to elope again...2/17/15 stayed in a hotel all night and day with her (different) boyfriend while on a home visit in [name of city]...." Client A's ISP did not include proactive measures and objectives to teach client A protective measures regarding personal safety, elopement, and safety skills. Client A's ISP indicated she required twenty-four hour a day staff supervision.</p> <p>-Client A's 10/18/14, 9/24/14, and 9/2/14 IDT (Interdisciplinary Team) meeting notes indicated "1:1 (One on One) staff supervision" was implemented after each incident of elopement and did not indicate when the one on one staff supervision was changed.</p> <p>-Client A's 5/4/2015 "Risk Management Assessment and Plan" indicated client A "Presents a risk" for the following areas of assessment: "Wears glasses...Some balance issues due to her left leg being somewhat shorter than her right, walks with a limp...slight weakness in her hand...is not able to administer medications independently...panic attacks...(does not) associate consequences with actions [client A] has</p>			

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	<p>a history of inappropriate interactions with males as well as placing herself in potentially dangerous situations in her interactions with males. Would benefit from 24/7 supervision to ensure her health and safety and general welfare... (does not) inform support person (the staff) of plans when leaving home area. [Client A] has history of elopement...would readily get into a car with a man she does not know if he paid attention to her...(does not) exhibit socially accepted behaviors in public... (does not) have ability to remain alone in any environment. [Client A] lacks the ability to do this independently...Would not likely defend herself...may not be able to recognize what is considered abuse and therefore not report appropriately...[Client A] needs assistance with her finances...has a history of cutting herself...[Client A] requires 24 hour awake supervision."</p> <p>-Client A's 2/2014 BSP indicated identified targeted behaviors of Panic Attack, Inappropriate with males, and vacating (elopement). Client A's BSP indicated "Vacating...Staff should be aware of [client A's] whereabouts at all times...If [client A] elopes from staff, keep her in sight and calmly request that she make a positive choice, and return to the home or vehicle with you...If [client</p>			

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	<p>A] appears upset ask her if she wants to talk about what is bothering her, or if she needs time to be alone to calm herself down. If she refuses to return, calmly request again that she return to the location that she eloped from. Continue to follow her, but do not make a big deal out of it, do not discuss the situation further. Give [client A] time to think about it, 15 min. (minutes), while you are following her and monitoring for safety. If [client A] refuses after 15 minutes to return, offer her another opportunity to return, if she continues to refuse after this offer, contact the PD (Program Director) or PD (Program Director) on call for further instruction, do not inform [client A] that you are contacting the PD, do not make a fuss or a big deal about contacting the PD. If [client A's] elopement has put her in a potentially dangerous situation in a high traffic area, implement least restrictive agency approved physical intervention (PIA) to maintain safety. If possible a staff member that is not actively intervening with [client A] contact the PD...." Client A's BSP did not include the agency's definition for PIA.</p> <p>On 6/24/15 at 12:30pm, the facility's undated "Physical Intervention Alternatives" policy and procedure located in the staff communication book</p>			

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	<p>for "Physical restraint: All Indiana Mentor staff are trained upon employment and re-trained annually on these procedures. Any escorts/restraints should be released as quickly as possible. If a restraint lasts for 10 minutes, the client should be released and staff should attempt blocking/avoidance unless it is unsafe to do so. If blocking/avoidance continues to be ineffective or unsafe, reinstate physical restraint for 10 minute intervals attempting to release the client when it is safe to do so. If a client does not respond to proactive measures or non-restrictive measures use restrictive company approved PIA (Physical Intervention Alternatives) techniques listed in this order: Physical restraints should be used only when physical aggression will likely result in harm to oneself, others, or when property destruction might affect peoples' health and safety otherwise use blocking/avoidance. Staff may skip less restrictive measure only if health/safety is an imminent threat. Escorts: Side by side escort walking slightly behind and to the side of the person. Hand below elbow 'L' shaped hand cupping the elbow. Hand behind elbow and hand mid-back. Restraints only to be used if blocking, avoidance or escort is not safe. One arm hold uses 'L' shaped hand to restrict one of the client's arms. Two arm hold, same</p>			

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	<p>as one arm but uses second arm to restrain client's flailing arm to the side still only restraining one arm. One arm hold to the floor-client in sitting position. Floor hold (two person) use one arm to the floor restraint, second staff used to restrain legs of the client."</p> <p>On 6/24/15 at 10:30am, an interview was conducted with the QIDP/PD. The QIDP/PD stated client A did not recognize danger, "required" twenty-four hour staff supervision, and had eloped from the group home on 6/17/15. The QIDP/PD indicated client A's ISP, BSP, and risk plans should have been implemented on 6/17/15. The QIDP/PD stated she was filling out the paperwork for the application of client A's Protect Life Saver program and indicated after the application was submitted it "would be at least two months or longer" before client A would be available for the program. When asked what protective measures and corrective actions had been developed after client A's continued elopement behaviors, the QIDP/PD stated "We added one on one staff" supervision. When asked why client A did not have one on one staff supervision on 6/17/15, the QIDP/PD indicated there were two (2) staff in the home on the schedule and one of the two was gone with client E on a community outing</p>			

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W 0227  Bldg. 00	<p>which left one staff alone with seven (7) clients. The QIDP/PD indicated there were three (3) additional clients living in the group home who were elopement risks. The QIDP/PD stated she was "unsure" when client A's one on one staff supervision was discontinued. The QIDP/PD stated client A "did not recognize danger," "required staff supervision," and was "unsafe" when she runs into traffic on the streets during elopements on 6/17/15. The QIDP/PD indicated staff training records were not available for review at this time.</p> <p>On 6/25/15 at 10:15 AM, an interview was conducted with the QIDP/PD. The QIDP/PD indicated no staff training records were available for review at this time.</p> <p>This federal tag relates to complaint #IN00176248.</p> <p>9-3-3(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on record review and interview for 3 of 3 sampled clients (clients A, B, and</p>	W 0227	1.Client A's ISP and BSP have	07/17/2015			

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	<p>C), the facility failed to ensure client A, B, and C's ISPs (Individual Support Plans) and BSPs (Behavior Support Plans) included specific interventions to address client A, B, and C's elopement behaviors and teach personal safety.</p> <p>Findings include:</p> <p>1. On 6/24/15 at 11:00am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed. The review indicated the following for client A:</p> <p>-A 6/18/15 BDDS report for an incident on 6/17/15 at 6:00pm indicated "On Wednesday, June 17, 2015 at 5:52pm" the Residential Manager (RM) notified the Qualified Intellectual Disabilities Professional/Program Director (QIDP/PD) that client A "had eloped from her Indiana Mentor Group Home. Of the two staff on shift, one staff was on an outing with other clients in the Group Home and one was behind with the client that eloped (client A) and a few other clients." The report indicated client A eloped and "the one staff member (at the group home) walked to the end of the driveway and watched the client while talking to [the RM]...eventually reporting she could no longer see the client." The report indicated client A arrived at a</p>		<p>been updated to include elopement as a targeted behavior. Included in the plans are strategies for staff to use to know how and when to intervene to ensure Client A's safety regarding elopement behaviors.</p> <p>QIDP will receive retraining to include ensuring that all consumers Behavior Support Plans include all identified targeted behaviors and also include strategies for how staff are to address targeted behaviors and prevent future occurrences. A review of all consumers Behavior Support plans will be done to ensure all targeted behaviors are identified in the plans and strategies for how staff should address and prevent targeted behaviors.</p> <p>QIDP has developed a goal for Client A to teach her about personal safety. Client A ISP and Risk plan have been updated to reflect the new goal/objectives. QIDP will receive retraining on ensuring that client specific goals/objectives are developed after a need has been identified to assist consumers in working towards independence.</p> <p>1. Client B BSP has been updated to include the target behavior of elopement, including a description of Client B elopement behavior and has identified client specific strategies</p>	

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	<p>different all male group home "approximately a 1/2 (half) hour (sic) later; staff was unable to ascertain how she got there...[client A] refused to go back to her Group Home. Police were called and when they arrived, they told the client she had the right to elope and because she was not a threat of harm to herself or those around her, they would leave. Prior to leaving, they (the Police) told [client A] she should go back home which was approximately 7:00pm. [Client A] got into the Group Home van, cursing at staff, stating she was going to run away again as soon as she got there (back to her Group Home). [Client A] arrived to (her Group Home) shortly before 8:00pm, still cursing at staff, laughing hysterically, and threatening to run. Both the staff on shift kept [client A] within their sight because of [client A's] threats." The report indicated client A took her 8:00pm medications and "Afterwards, [client A] told the staff to stop following her and then she started to use closed fist punches to one staff member whom was blocking [client A's] way to an exit door. The staff member attempted to use the one arm hold...The second staff was attempting to stop two other clients whom were threatening to elope at the same time. The first staff member released [client A's] arm and [client A] ran out of the home. At that</p>		<p>for staff to use to prevent future elopement behaviors.</p> <p>QIDP will receive retraining to include ensuring that all consumers Behavior Support Plans include all identified targeted behaviors and also include strategies for how staff are to address targeted behaviors and prevent future occurrences. A review of all consumers Behavior Support plans will be done to ensure all targeted behaviors are identified in the plans and strategies for how staff should address and prevent targeted behaviors.</p> <p>QIDP has developed a goal for Client B to teach her about personal safety. Client B ISP and Risk plan have been updated to reflect the new goal/objectives. QIDP will receive retraining on ensuring that client specific goals/objectives are developed after a need has been identified to assist consumers in working towards independence.</p> <p>1. Client C's BSP has been updated to include specific instructions for when staff are to utilize the police or other emergency service personnel to intervene regarding Client C SIB, Physical aggression and/or elopement behaviors.</p> <p>QIDP will receive retraining to</p>	

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	<p>time the [Residential Manager (RM)] was already parked in her car in front of the [Group Home] reporting to the [PD (Program Director)] that [client A] was threatening to leave when [client A] did just that...The [RM] turned her car on and followed [client A] down the street and into the apartment complex nearby where [the RM] lost sight of [client A]." The report indicated the RM and the PD "drove around for a few minutes," could not locate client A, and called the Police. The report indicated "the time [client A] eloped was approximately 8:37pm. At this time, [client A] has still not been located by the Police nor Mentor staff assisting in looking for [client A]...." No corrective action was available for review.</p> <p>Summary of Internal Investigative Report dated 6/22/15 indicated the following: -"Brief Summary of incident: On 6/17/15 at 5:52pm, [client A] eloped from the home, was located by staff and returned to the group home. [Client A] eloped a second time after 8pm and was unable to be located. A report was filed with the [Name of Police Agency]."</p> <p>-The investigation indicated those interviewed were three direct care staff, the Residential Manager, and the Program Director. The investigation was</p>		<p>include ensuring that all consumers Behavior Support Plans are comprehensive and include all identified targeted behaviors and also include strategies for how staff are to address targeted behaviors and prevent future occurrences. A review of all consumers Behavior Support plans will be done to ensure all targeted behaviors are identified in the plans and strategies for how staff should address and prevent targeted behaviors.</p> <p>QIDP has developed a goal for Client C to teach her about personal safety. Client C ISP and Risk plan have been updated to reflect the new goal/objectives. QIDP will receive retraining on ensuring that client specific goals/objectives are developed after a need has been identified to assist consumers in working towards independence.</p> <p>Area Director will complete an audit of all consumers Behavior Support Plans, ISPs and Risk plans to ensure that specifics of what PIA techniques to use to prevent consumers targeted behaviors and when police or emergency personnel are to be called to intervene with behaviors are specifically outlined in consumers Behavior Support Plans, ISPs and risk plans as needed.</p>	

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	<p>not thorough in that the investigation did not indicate completed interviews with clients who were present at the time of each elopement.</p> <p>- "Background of client and their placement...(Client A's diagnoses included but were not limited to:) Mild Intellectual Disability, Traumatic Brain Injury with behavior disturbance, ADHD (Attention Deficit Hyperactivity Disorder), Seizure DO (Disorder)... [Client A's] history of elopement started prior to her placement at Indiana Mentor, [client A's] ISP and Risk Plan states she experiences Panic Attacks. On 9/2/14 [client A] was missing for over 12 hours and was found in the bed of a client after entering his home through a window without staff knowledge...[Client A's] mother became her legal guardian on 7/21/14."</p> <p>- "Interview" with the RM indicated she followed client A in her car during client A's second elopement (6/17/15 at 8:37pm) "...when [client A] reached [name of street] [Client A] attempted to dart into traffic so [the RM] used her car to block [client A] from getting hit by other cars as [the RM] pleaded for [client A] to get in [the RM's] car." The RM indicated she followed client A until she entered the apartment complex where the</p>		<p>For the next three months, the Area Director will review all changes or annual updates made to any consumers Behavior Support plans completed by the QIDP to ensure that specific PIA techniques recommended to use to prevent consumers targeted behaviors and when staff are to utilize emergency personnel to intervene with behaviors is specifically outlined in their BSP, ISP and Risk plans.</p> <p>Ongoing after the three months, the Area Director will complete a random audit of a minimum of 2 consumers per month BSP, ISP and Risk plans developed by the QIDP to ensure that specific PIA techniques recommended to use to prevent consumers targeted behaviors and when staff are to utilize emergency personnel to intervene with behaviors is specifically outlined in their BSP, ISP and Risk plans.</p> <p>Responsible Party: Home Manager, QIDP, Regional Quality Assurance Specialist, Area Director.</p>		

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	<p>RM lost sight of client A.</p> <p>- "Interview" with Group Home Staff (GHS) #1 indicated she had picked up client A from day services, returned to the group home, and client A had called her mother and family members without making contact on the telephone. GHS #1 indicated client A became upset and "she [client A] was leaving and ran out the door...[GHS #1] was by herself with clients...she was able to see [client A] from the end of the driveway until [client A] ducked behind the school...[GHS #1] received call from the [RM] to meet at [the second group home]...[client A] was out of control (when GHS #1 arrived at the second group home)...[GHS #1] said [client A] finally agreed to get in the van, but said she was going to run away again when she got home. [GHS #1] said on the way home [client A] was asked to show them (the staff) where [client A] had knocked on the door and got a ride to [the second group home]. [GHS #1] said [client A] said she knocked on the door, cried, saying she was lost, and needed a ride to [name of second group home]...."</p> <p>- "Interview" with GHS #2 indicated she was out shopping with client E, returned in the van to the group home to find GHS #1 standing in the driveway looking for client A. GHS #2 "said when [client A]</p>			

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	<p>returned home she was treated like a rock star by her housemates. [GHS #2] said [client A] was being congratulated, high fived, and generally encouraged for running away. [GHS #2] said there was a lot of commotion and the noise level was high...[Client A] continued to threaten to leave. Attempts to calm [client A] were not successful. [GHS #2] said at about 8:30pm, [client A] ran out the front door and all her housemates ran to the front of the house and cheered her on."</p> <p>-"Interview" with the PD (Program Director) indicated "...On 6/22/15 she received a call from [GHS #7] a [substitute staff at the group home] the morning of 6/20/15 (Saturday). [PD] said [GHS #7] informed her that the police had [client A] at 34th (Street) and Meridian St. and was being taken to [Name of Hospital] for evaluation. [PD] said she met [client A] at the emergency room. [PD] said she had only a few minutes alone with [client A] before [client A's] mother arrived. [PD] said [client A] stated she made \$60.00 for sex, but then was forced to take drugs and was passed around for sex, which she did not like. [PD] said [client A's] mother took [client A] home following the forensic evaluation. [PD] said she has applied for the Project Lifesaver (electronic monitoring device), which would not be</p>			

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	<p>available for up to two months due to availability."</p> <p>-"Interview" with client A's mother/guardian indicated client A's mother/guardian had been driving to Indianapolis from [name of city] in an attempt to locate client A on the street. Client A's mother/guardian indicated she was tracing telephone calls made by client A when client A called family members out of town and had traced client A who was using other people's cell phones which she had borrowed on the street and a pay phone at a bus stop. Client A's mother/guardian indicated she was at the hospital with client A on 6/20/15 after being notified that client A had been found. Client A's mother/guardian indicated client A "told her she (client A) did make \$60.00 from a man who then started pimping [client A] out...(client A) was forced to consume drugs and was passed from person to person including a women for sex...when [client A] told them to stop she was told to get her things and get out...(client A) tested positive for cocaine, opiates, and THC (Tetrahydrocannabinol, a chemical responsible for most of marijuana's psychological effects)...(client A) is experiencing pain with rectal and vaginal bleeding...(Client A) is having panic attacks and nightmares...." Client A's</p>			

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	<p>mother/guardian stated "she intends to keep [client A] home until the Project Life Saver can be put into place."</p> <p>-"Conclusion" indicated client A eloped twice on the evening of 6/17/15. Evidence supports physical intervention was not used in order to keep client A from leaving the group home. The investigation was not thorough in that it did not document witness statements from other clients present in the home and during both elopements of client A. The investigation did not indicate recommendations and corrective actions to protect client A and to protect other clients from their identified behaviors. The investigation did not indicate documentation of staff implementing client A's BSP, ISP, or the effectiveness of PIA (Physical Intervention Alternatives) techniques to prevent the incident from escalating from client A's elopement behaviors.</p> <p>CI #2 stated client A "does not understand consent and could not give consent." CI #2 stated client A had "told (CI #2) that she was passed around from man to man and some women" for sex. CI #2 indicated client A told her she left the group home the second time on 6/17/15, hitchhiked to [name of neighborhood], walked the streets, met</p>			

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	<p>the man who told client A she was pretty, and that he could show client A how to make money. CI #2 indicated client A told CI #2 that the man had sex with client A multiple times, passed her to other men and women for sex to exchange for money, lived on the streets of Indianapolis, consumed cocaine, marijuana, and opiates. CI #2 indicated on Saturday, 6/20/15 client A said she was asked to step outside an apartment during a visit to a new location with the unknown man, client A stepped outside the apartment in the doorway, sat down, fell asleep, and woke up with the Police Officers looking at her.</p> <p>Client A's record was reviewed on 6/24/15 at 11:50am.</p> <p>-Client A's 5/4/15 ISP indicated client A had "targeted behaviors" which included: Panic Attacks, Inappropriate interaction with males, and vacating (elopement) behaviors. Client A's ISP indicated she had elopement behaviors 9/2/14 when client A "was discovered to have eloped from her group home. She was found on 9/3/14 at 8:15am at a [name of group home] that of her alleged boyfriend... [Client A] had consensual sex with her alleged boyfriend and also went to sleep next to him during the night...9/24/14 [client A] was found under her bedroom covers with two other clients whom</p>			

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	<p>alleged that sexual misconduct had taken place in the form of her (female) housemate touching her in the breast and vagina area. The allegation could not be substantiated...10/18/14 at 8:00pm, [client A] successfully eloped from the group home and was later found at her (different) boyfriend's [name of group home] at 8:28pm. She willingly transported back to her group home but threatened to elope again...2/17/15 stayed in a hotel all night and day with her (different) boyfriend while on a home visit in [name of city]...." Client A's ISP did not include proactive measures and objectives to teach client A protective measures regarding personal safety, elopement, and safety skills.</p> <p>-Client A's 10/18/14, 9/24/14, and 9/2/14 IDT (Interdisciplinary Team) meeting notes indicated "1:1 (One on One) staff supervision" was implemented after each incident of elopement and did not indicate when the one on one staff supervision was changed.</p> <p>-Client A's 5/4/2015 "Risk Management Assessment and Plan" indicated client A "Presents a risk" for the following areas of assessment: "Wears glasses...Some balance issues due to her left leg being somewhat shorter than her right, walks with a limp...slight weakness in her</p>			
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	<p>hand...is not able to administer medications independently...panic attacks...(does not) associate consequences with actions [client A] has a history of inappropriate interactions with males as well as placing herself in potentially dangerous situations in her interactions with males. Would benefit from 24/7 supervision to ensure her health and safety and general welfare... (does not) inform support person (the staff) of plans when leaving home area. [Client A] has history of elopement...would readily get into a car with a man she does not know if he paid attention to her...(does not) exhibit socially accepted behaviors in public... (does not) have ability to remain alone in any environment. [Client A] lacks the ability to do this independently... Would not likely defend herself...may not be able to recognize what is considered abuse and therefore not report appropriately...[Client A] needs assistance with her finances...has a history of cutting herself...[Client A] requires 24 hour awake supervision."</p> <p>-Client A's 2/2014 BSP indicated identified targeted behaviors of Panic Attack, Inappropriate with males, and vacating (elopement). Client A's BSP indicated "Vacating...Staff should be aware of [client A's] whereabouts at all</p>			

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	<p>times...If [client A] elopes from staff, keep her in sight and calmly request that she make a positive choice, and return to the home or vehicle with you...If [client A] appears upset ask her if she wants to talk about what is bothering her, or if she needs time to be alone to calm herself down. If she refuses to return, calmly request again that she return to the location that she eloped from. Continue to follow her, but do not make a big deal out of it, do not discuss the situation further. Give [client A] time to think about it, 15 min. (minutes), while you are following her and monitoring for safety. If [client A] refuses after 15 minutes to return, offer her another opportunity to return, if she continues to refuse after this offer, contact the PD (Program Director) or PD (Program Director) on call for further instruction, do not inform [client A] that you are contacting the PD, do not make a fuss or a big deal about contacting the PD. If [client A's] elopement has put her in a potentially dangerous situation in a high traffic area, implement least restrictive agency approved physical intervention (PIA) to maintain safety. If possible a staff member that is not actively intervening with [client A] contact the PD...."</p> <p>On 6/24/15 at 10:30am, an interview was conducted with the QIDP/PD. The</p>			

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	<p>QIDP/PD stated client A did not recognize danger, "required" twenty-four hour staff supervision, and had eloped from the group home on 6/17/15. When asked what protective measures and corrective actions had been developed after client A's continued elopement behaviors, the QIDP/PD stated "We added one on one staff" supervision. When asked why client A did not have one on one staff supervision on 6/17/15, the QIDP/PD indicated there were two (2) staff in the home on the schedule and one of the two was gone with client E on a community outing which left one staff alone with seven (7) clients. The QIDP/PD indicated there were three (3) additional clients living in the group home who were elopement risks. The QIDP/PD stated she was "unsure" when client A's one on one staff supervision was discontinued. The QIDP/PD stated client A "did not recognize danger," "required staff supervision," and was "unsafe" when she runs into traffic on the streets during elopements on 6/17/15. The QIDP/PD indicated client A's ISP, BSP, and Risk Plans did not document proactive strategies to protect and to teach client A regarding personal safety and elopement.</p> <p>2. For client B: -A 4/29/15 BDDS report for an incident</p>			

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	<p>on 4/28/15 at 5:10pm indicated client B returned from a psychiatric appointment "agitated that she was having a med (medication) increase. Shortly later, she was prompted by staff to turn her music down." The report indicated client B "responded by flipping the living room table and charging the staff." The report indicated client B "eloped out the front door where staff watched her from the front porch. Staff watched [client B] go to the neighbor's house on both sides of the group home, knocking on their doors, staff had client in sight from the group home front porch. Finally, a person answered the door to one of the houses and [client B] went inside where staff lost sight of her. At that time, [the PD/QIDP] was notified. Client returned to the group home site within 2 minutes stating she called her sister." The report indicated client B told the PD/QIDP that the staff on duty at the group home had "pushed [client B] and that was why she had to go call her sister...Plan to resolve...Client's plan to be changed to include that of Elopement."</p> <p>On 6/24/15 at 2:40pm and on 6/25/15 at 8:25am, client B's record was reviewed. Client B's 9/2014 BSP did not include elopement behaviors. An additional non approved HRC (Human Rights Committee) 4/28/15 BSP and 4/28/15</p>			

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	<p>ISP included elopement behavior on the list of targeted behaviors and did not include interventions staff should use and did not include a written description of client B's elopement behavior.</p> <p>An interview was conducted with PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) on 6/25/15 at 10:15 AM. The PD/QIDP indicated client B's BSP should include specific instructions and/or interventions regarding what staff should do when client B elopes. The PD/QIDP indicated client B should be supervised by facility staff twenty-four hours a day seven days a week.</p> <p>3. For client C: -A 5/15/15 BDDS report for an incident on 5/14/15 at 5:50 PM indicated, "At 5:50 PM, the PD (Program Director) was notified that [client C] had left the premises of the group home walking on the sidewalk. [The PD] informed the staff they would arrive to (sic) the site in 25-30 minutes to assist. Staff reported they stayed with the [client C], walking down the street sidewalk of the group home, continuing to follow and attempt(ing) to redirect [client C] when [client C] turned onto [road] a busy street. At that time, [client C] stepped off the sidewalk and into the street, back and</p>			

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	<p>forth numerous times in an unsafe manner. The staff was able to guide [client C] back onto the sidewalk each time, however, felt that [client C] was attempting to harm themselves (sic) so the staff member called 911. Police intercepted the client when she was walking on [street] near [street]. Police called the group home, requesting the second staff member, working that night and attending to the other clients, pick [client C] and the first staff member up from their position. The second staff member gathered up the clients she was caring for, placed them into the van and picked up the did so (sic). [PD #1] arrived to (sic) the site at 6:20 PM to find that [client C] had been brought back to the site by staff who picked her up from police and the first staff member's care."</p> <p>-A 4/13/15 BDDS report for an incident on 4/12/15 at 10:45 PM indicated, "[HM (Home Manager)] called (the) on-call [PD] to report that [client C] had walked away from the group home. Staff called 911 for additional supports and when staff hung up the phone, [client C] was back at the group home. [Client C] was out of staff's sight for 2 minutes before returning back to (the) group home."</p> <p>Client C's record was reviewed on 6/24/15 at 2:00 PM. Client C's 9/20/14</p>			

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	<p>BSP indicated the following:</p> <p>- "Aggressive Outburst: (1.) Immediately request that [client C] cease the behavior. Request that she calm herself down. Inform [client C] that once she is calm, you will spend time with her talking about what is upsetting her. Allow her to tell you what she is upset about. All you need to do is listen to her. When she has finished encourage her and engage with her in an activity such as coloring, exercise or playing a game; (2.) If the behavior continues and is directed toward other person in the environment, ask them to leave the area for their own safety. Prompt [client C] to engage in a calming activity; (3.) Do not touch [client C] but tell her she will be okay, ask her what you can do to assist her with calming down; (4.) If [client C] is unable or unwilling to calm down or if the outburst is a danger to self or others proceed to step 5; (5.) Direct [client C] to discontinue the behavior immediately; (6.) If the aggressive outburst continues and is a risk of injury to self or others use the agency approved minimum amount of physical guidance necessary to stop the behavior. Use the techniques taught by Indiana Mentor (PIA)."</p> <p>- "Vacating. Staff should be aware of [client C's] whereabouts at all times. In</p>			

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	<p>inclement weather, keep protective clothing for staff and [client C] near the door so that it is easily available if [client C] exits the home. If [client C] elopes from staff, keep her in sight and calmly request that she make a positive choice and return to the home or vehicle with you. (3.) (sic) If [client C] responds, thank her for returning and continue with the activity or outing that was going on previous to her elopement. If [client C] appears upset ask her if she wants to talk about what is bothering her or if she needs time to be alone to calm herself down. (4.) If she refuses to return, calmly request again that she return to the location that she eloped from. Continue to follow her but do not make a big deal out of it, do not discuss the situation further. Give [client C] time to think about it (15 minutes) while you are following her and monitoring for safety. (5.) If [client C] refuses after 15 minutes to return, offer her another opportunity to return, if she continues to refuse after this offer, contact the PD or PD on-call for further instructions."</p> <p>Client C's 5/4/15 "Risk Management Plan" indicated client C did not "associate consequences with actions, [client C] receives 24/7 (twenty-four hours and day seven days a week) staff support and supervision...[client C] is</p>			

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W 0240 Bldg. 00	<p>impulsive and can be defiant...[client C] will not be unattended in the community...law enforcement may get involved due to elopement."</p> <p>An interview was conducted with PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) on 6/25/15 at 10:15 AM. The PD/QIDP indicated client C's BSP should include specific instructions or interventions regarding when staff should utilize police or other emergency service personnel to intervene regarding client C's physical aggression or elopement behaviors. PD/QIDP indicated client C's police involvement component was indicated on client C's Risk Plan. The PD/QIDP indicated client C's BSP should specify how staff are to address client C's elopement behaviors.</p> <p>This federal tag relates to complaint #IN00176248.</p> <p>9-3-4(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on record review and interview for 3 of 3 sampled clients (clients A, B, and</p>	W 0240	Client A Behavior Support Plan has been updated to include the use of Physical Intervention	07/17/2015

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	<p>C), the facility failed to ensure client A, B, and C's BSP (Behavior Support Plan) indicated when facility staff should contact emergency service personnel and/or described interventions to promote independence regarding client A, B, and C's elopement and/or physical aggression behavior incidents.</p> <p>Findings include:</p> <p>1. On 6/24/15 at 11:00am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed. The review indicated the following for client A:</p> <p>-A 6/18/15 BDDS report for an incident on 6/17/15 at 6:00pm indicated "On Wednesday, June 17, 2015 at 5:52pm" the Residential Manager (RM) notified the Qualified Intellectual Disabilities Professional/Program Director (QIDP/PD) that client A "had eloped from her Indiana Mentor Group Home. Of the two staff on shift, one staff was on an outing with other clients in the Group Home and one was behind with the client that eloped (client A) and a few other clients." The report indicated client A eloped and "the one staff member (at the group home) walked to the end of the driveway and watched the client while talking to [the RM]...eventually reporting</p>		<p>Alternative (PIA) techniques and what specific techniques to use with Client A to prevent future elopement behaviors. Client A Individual Support Plan (ISP) and Risk Plans have been updated to include changes made regarding PIA in Client A Behavior Support Plan.</p> <p>All direct care staff will receive retraining on the changes made to Client A Behavior Support plan regarding the specific PIA techniques to use with Client A to prevent future elopement behaviors.</p> <p>The QIDP will complete an audit of all other consumers Behavior Support Plans to ensure that if the use of PIA is recommended for use to prevent targeted behaviors that specifics of what techniques are recommended are outlined in consumers Behavior Support Plans. If PIA is identified in consumers Behavior Support Plans the QIDP will update the consumers ISP and Risk plans to reflect any changes.</p> <p>QIDP will receive retraining to include ensuring that if use of PIA techniques is recommended to prevent targeted behaviors that the specific of what techniques to use are outlined in consumers Behavior Support Plans, ISP and Risk plans.</p>				

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	<p>she could no longer see the client." The report indicated client A arrived at a different all male group home "approximately a 1/2 (half) hour (sic) later; staff was unable to ascertain how she got there...[client A] refused to go back to her Group Home. Police were called and when they arrived, they told the client she had the right to elope and because she was not a threat of harm to herself or those around her, they would leave. Prior to leaving, they (the Police) told [client A] she should go back home which was approximately 7:00pm. [Client A] got into the Group Home van, cursing at staff, stating she was going to run away again as soon as she got there (back to her Group Home). [Client A] arrived to (her Group Home) shortly before 8:00pm, still cursing at staff, laughing hysterically, and threatening to run. Both the staff on shift kept [client A] within their sight because of [client A's] threats." The report indicated client A took her 8:00pm medications and "Afterwards, [client A] told the staff to stop following her and then she started to use closed fist punches to one staff member whom was blocking [client A's] way to an exit door. The staff member attempted to use the one arm hold...The second staff was attempting to stop two other clients whom were threatening to elope at the same time. The first staff</p>		<p>Client B BSP has been updated to include the target behavior of elopement, including a description of Client B elopement behavior and has identified client specific strategies for staff to use to prevent future elopement behaviors.</p> <p>QIDP will receive retraining to include ensuring that all consumers Behavior Support Plans include all identified targeted behaviors and also include strategies for how staff are to address targeted behaviors and prevent future occurrences. A review of all consumers Behavior Support plans will be done to ensure all targeted behaviors are identified in the plans and strategies for how staff should address and prevent targeted behaviors.</p> <p>Client C's BSP has been updated to include specific instructions for when staff are to utilize the police or other emergency service personnel to intervene regarding Client C SIB, Physical aggression and/or elopement behaviors.</p> <p>QIDP will receive retraining to include ensuring that all consumers Behavior Support Plans are comprehensive and identify strategies for how to prevent future occurrences. A review of all consumers Behavior Support plans will be done to</p>	

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	<p>member released [client A's] arm and [client A] ran out of the home. At that time the [Residential Manager (RM)] was already parked in her car in front of the [Group Home] reporting to the [PD (Program Director)] that [client A] was threatening to leave when [client A] did just that...The [RM] turned her car on and followed [client A] down the street and into the apartment complex nearby where [the RM] lost sight of [client A]." The report indicated the RM and the PD "drove around for a few minutes," could not locate client A, and called the Police. The report indicated "the time [client A] eloped was approximately 8:37pm. At this time, [client A] has still not been located by the Police nor Mentor staff assisting in looking for [client A]...."</p> <p>Summary of Internal Investigative Report dated 6/22/15 indicated the following: -"Brief Summary of incident: On 6/17/15 at 5:52pm, [client A] eloped from the home, was located by staff and returned to the group home. [Client A] eloped a second time after 8pm and was unable to be located. A report was filed with the [Name of Police Agency]."</p> <p>-The investigation indicated those interviewed were three direct care staff, the Residential Manager, and the Program Director. The investigation was</p>		<p>ensure all targeted behaviors are identified in the plans and strategies for how staff should address and prevent targeted behaviors.</p> <p>Area Director will complete an audit of all consumers Behavior Support Plans, ISPs and Risk plans to ensure that specifics of what PIA techniques to use to prevent consumers targeted behaviors and when police or emergency personnel are to be called to intervene with behaviors are specifically outlined in consumers Behavior Support Plans, ISPs and risk plans as needed.</p> <p>For the next three months, the Area Director will review all changes or annual updates made to any consumers Behavior Support plans completed by the QIDP to ensure that specific PIA techniques recommended to use to prevent consumers targeted behaviors and when staff are to utilize emergency personnel to intervene with behaviors is specifically outlined in their BSP, ISP and Risk plans.</p> <p>Ongoing after the three months, the Area Director will complete a random audit of a minimum of 2 consumers per month BSP, ISP and Risk plans developed by the QIDP to ensure that specific PIA techniques recommended to use to prevent consumers targeted</p>	

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	<p>not thorough in that the investigation did not indicate completed interviews with clients who were present at the time of each elopement.</p> <p>-"Background of client and their placement...(Client A's diagnoses included but were not limited to:) Mild Intellectual Disability, Traumatic Brain Injury with behavior disturbance, ADHD (Attention Deficit Hyperactivity Disorder), Seizure DO (Disorder)... [Client A's] history of elopement started prior to her placement at Indiana Mentor, [client A's] ISP and Risk Plan states she experiences Panic Attacks. On 9/2/14 [client A] was missing for over 12 hours and was found in the bed of a client after entering his home through a window without staff knowledge...[Client A's] mother became her legal guardian on 7/21/14."</p> <p>-"Interview" with the RM indicated she followed client A in her car during client A's second elopement (6/17/15 at 8:37pm) "...when [client A] reached [name of street] [Client A] attempted to dart into traffic so [the RM] used her car to block [client A] from getting hit by other cars as [the RM] pleaded for [client A] to get in [the RM's] car." The RM indicated she followed client A until she entered the apartment complex where the</p>		<p>behaviors and when staff are to utilize emergency personnel to intervene with behaviors is specifically outlined in their BSP, ISP and Risk plans.</p> <p>Responsible Party: Home Manager, QIDP, Regional Quality Assurance Specialist, Area Director.</p>	

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	<p>RM lost sight of client A.</p> <p>-"Interview" with Group Home Staff (GHS) #1 indicated she had picked up client A from day services, returned to the group home, and client A had called her mother and family members without making contact on the telephone. GHS #1 indicated client A became upset and "she [client A] was leaving and ran out the door...[GHS #1] was by herself with clients...she was able to see [client A] from the end of the driveway until [client A] ducked behind the school...[GHS #1] received call from the [RM] to meet at [the second group home]...[client A] was out of control (when GHS #1 arrived at the second group home)...[GHS #1] said [client A] finally agreed to get in the van, but said she was going to run away again when she got home. [GHS #1] said on the way home [client A] was asked to show them (the staff) where [client A] had knocked on the door and got a ride to [the second group home]. [GHS #1] said [client A] said she knocked on the door, cried, saying she was lost, and needed a ride to [name of second group home]...."</p> <p>-"Interview" with GHS #2 indicated she was out shopping with client E, returned in the van to the group home to find GHS #1 standing in the driveway looking for client A. GHS #2 "said when [client A]</p>			

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	<p>returned home she was treated like a rock star by her housemates. [GHS #2] said [client A] was being congratulated, high fived, and generally encouraged for running away. [GHS #2] said there was a lot of commotion and the noise level was high...[Client A] continued to threaten to leave. Attempts to calm [client A] were not successful. [GHS #2] said at about 8:30pm, [client A] ran out the front door and all her housemates ran to the front of the house and cheered her on."</p> <p>-"Interview" with the PD (Program Director) indicated "...On 6/22/15 she received a call from [GHS #7] a [substitute staff at the group home] the morning of 6/20/15 (Saturday). [PD] said [GHS #7] informed her that the police had [client A] at 34th (Street) and Meridian St. and was being taken to [Name of Hospital] for evaluation. [PD] said she met [client A] at the emergency room. [PD] said she had only a few minutes alone with [client A] before [client A's] mother arrived. [PD] said [client A] stated she made \$60.00 for sex, but then was forced to take drugs and was passed around for sex, which she did not like. [PD] said [client A's] mother took [client A] home following the forensic evaluation. [PD] said she has applied for the Project Lifesaver (electronic monitoring device), which would not be</p>			

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	<p>available for up to two months due to availability."</p> <p>-"Interview" with client A's mother/guardian indicated client A's mother/guardian had been driving to Indianapolis from [name of city] in an attempt to locate client A on the street. Client A's mother/guardian indicated she was tracing telephone calls made by client A when client A called family members out of town and had traced client A who was using other people's cell phones which she had borrowed on the street and a pay phone at a bus stop. Client A's mother/guardian indicated she was at the hospital with client A on 6/20/15 after being notified that client A had been found. Client A's mother/guardian indicated client A "told her she (client A) did make \$60.00 from a man who then started pimping [client A] out...(client A) was forced to consume drugs and was passed from person to person including a women for sex...when [client A] told them to stop she was told to get her things and get out...(client A) tested positive for cocaine, opiates, and THC (Tetrahydrocannabinol, a chemical responsible for most of marijuana's psychological effects)...(client A) is experiencing pain with rectal and vaginal bleeding...(Client A) is having panic attacks and nightmares...." Client A's</p>			

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	<p>mother/guardian stated "she intends to keep [client A] home until the Project Life Saver can be put into place."</p> <p>-"Conclusion" indicated client A eloped twice on the evening of 6/17/15. Evidence supports physical intervention was not used in order to keep client A from leaving the group home. The investigation was not thorough in that it did not document witness statements from other clients present in the home and during both elopements of client A. The investigation did not indicate recommendations and corrective actions to protect client A and to protect other clients from their identified behaviors. The investigation did not indicate documentation of staff implementing client A's BSP, ISP, or the effectiveness of PIA (Physical Intervention Alternatives) techniques to prevent the incident from escalating from client A's elopement behaviors.</p> <p>CI #2 stated client A "does not understand consent and could not give consent." CI #2 stated client A had "told (CI #2) that she was passed around from man to man and some women" for sex. CI #2 indicated client A told her she left the group home the second time on 6/17/15, hitchhiked to [name of neighborhood], walked the streets, met</p>			

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	<p>the man who told client A she was pretty, and that he could show client A how to make money. CI #2 indicated client A told CI #2 that the man had sex with client A multiple times, passed her to other men and women for sex to exchange for money, lived on the streets of Indianapolis, consumed cocaine, marijuana, and opiates. CI #2 indicated on Saturday, 6/20/15 client A said she was asked to step outside an apartment during a visit to a new location with the unknown man, client A stepped outside the apartment in the doorway, sat down, fell asleep, and woke up with the Police Officers looking at her.</p> <p>Client A's record was reviewed on 6/24/15 at 11:50am.</p> <p>-Client A's 5/4/15 ISP indicated client A had "targeted behaviors" which included: Panic Attacks, Inappropriate interaction with males, and vacating (elopement) behaviors. Client A's ISP indicated she had elopement behaviors 9/2/14 when client A "was discovered to have eloped from her group home. She was found on 9/3/14 at 8:15am at a [name of group home] that of her alleged boyfriend... [Client A] had consensual sex with her alleged boyfriend and also went to sleep next to him during the night...9/24/14 [client A] was found under her bedroom covers with two other clients whom</p>			

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	<p>alleged that sexual misconduct had taken place in the form of her (female) housemate touching her in the breast and vagina area. The allegation could not be substantiated...10/18/14 at 8:00pm, [client A] successfully eloped from the group home and was later found at her (different) boyfriend's [name of group home] at 8:28pm. She willingly transported back to her group home but threatened to elope again...2/17/15 stayed in a hotel all night and day with her (different) boyfriend while on a home visit in [name of city]...." Client A's ISP did not include proactive measures and objectives to teach client A protective measures regarding personal safety, elopement, and safety skills. Client A's ISP indicated she required twenty-four hour a day staff supervision. The review did not indicate documentation of when staff should utilize police or other emergency service personnel to intervene regarding client A's elopement behaviors.</p> <p>-Client A's 10/18/14, 9/24/14, and 9/2/14 IDT (Interdisciplinary Team) meeting notes indicated "1:1 (One on One) staff supervision" was implemented after each incident of elopement and did not indicate when the one on one staff supervision was changed.</p> <p>-Client A's 5/4/2015 "Risk Management</p>			

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	<p>Assessment and Plan" indicated client A "Presents a risk" for the following areas of assessment: "Wears glasses...Some balance issues due to her left leg being somewhat shorter than her right, walks with a limp...slight weakness in her hand...is not able to administer medications independently...panic attacks...(does not) associate consequences with actions [client A] has a history of inappropriate interactions with males as well as placing herself in potentially dangerous situations in her interactions with males. Would benefit from 24/7 supervision to ensure her health and safety and general welfare... (does not) inform support person (the staff) of plans when leaving home area. [Client A] has history of elopement...would readily get into a car with a man she does not know if he paid attention to her...(does not) exhibit socially accepted behaviors in public... (does not) have ability to remain alone in any environment. [Client A] lacks the ability to do this independently...Would not likely defend herself...may not be able to recognize what is considered abuse and therefore not report appropriately...[Client A] needs assistance with her finances...has a history of cutting herself...[Client A] requires 24 hour awake supervision."</p>			

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	-Client A's 2/2014 BSP indicated identified targeted behaviors of Panic Attack, Inappropriate with males, and vacating (elopement). Client A's BSP indicated "Vacating...Staff should be aware of [client A's] whereabouts at all times...If [client A] elopes from staff, keep her in sight and calmly request that she make a positive choice, and return to the home or vehicle with you...If [client A] appears upset ask her if she wants to talk about what is bothering her, or if she needs time to be alone to calm herself down. If she refuses to return, calmly request again that she return to the location that she eloped from. Continue to follow her, but do not make a big deal out of it, do not discuss the situation further. Give [client A] time to think about it, 15 min. (minutes), while you are following her and monitoring for safety. If [client A] refuses after 15 minutes to return, offer her another opportunity to return, if she continues to refuse after this offer, contact the PD (Program Director) or PD (Program Director) on call for further instruction, do not inform [client A] that you are contacting the PD, do not make a fuss or a big deal about contacting the PD. If [client A's] elopement has put her in a potentially dangerous situation in a high traffic area, implement least restrictive agency approved physical intervention (PIA) to			

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	<p>maintain safety. If possible a staff member that is not actively intervening with [client A] contact the PD...."</p> <p>On 6/24/15 at 10:30am, an interview was conducted with the QIDP/PD. The QIDP/PD indicated client A's ISP, BSP, and Risk Plans did not document proactive strategies to protect and to teach client A regarding personal safety and elopement. The QIDP/PD indicated client A's plans did not indicate when staff should utilize police or other emergency service personnel to intervene regarding client A's elopement behaviors.</p> <p>2. On 6/25/15 at 10:15 AM, an interview with the QIDP/PD was conducted. The QIDP/PD stated she was made aware of an incident on 6/17/15 before client A had left on her elopement "the first time." The QIDP/PD stated she was in the process of starting an investigation into that event when client A left on elopement the first time, then left on the second elopement, and was "attempting to locate" client A in the community. The QIDP/PD stated she "failed to report to BDDS and failed to investigate" client A's original incident documented in her DSR (Daily Service Record). The QIDP/PD provided an incomplete investigation summary which indicated "Date/Time of Incident: 6/17/15</p>			

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	<p>10:04am...Brief Summary of Incident: [client A] and [client B] had a physical altercation while in the van as the home was preparing to exit for morning transport." The investigation indicated the House Manager had indicated to the QIDP/PD that she would "give the details later" of what occurred and indicated client A had left the group home "and did not return" to the group home.</p> <p>On 6/25/15 at 10:15am, the QIDP/PD provided a review of client A and B's DSRs: -Client A's 6/17/15 DSR indicated on "6/17/15 from 7am-3pm, Housemates began to argue. Staff verbally intervened. [Client A] picked up a water bottle and threw it at her housemate [client B], hitting [client B] in the head. Staff was between the two clients attempting to keep distance between them, the housemate [client B] with the water bottle pushed staff toward and grabbed [client A] by the hair. Staff was getting hit from behind in the back and shoulder as [client B] attempted to punch [client A]. Staff used PIA (Physical Intervention Alternatives) during the altercation to release housemates hand from the hair grab. [Client A] was bent down and staff saw her glasses come off and fall to the floor. During this moment staff heard the back door open and housemate [client B]</p>			

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	<p>was no longer against staffs back. [Client A] began yelling and exited the van through the front passenger door. [Client A] was out of the van for several minutes with another staff when [client A] returned she was calm."</p> <p>-Client B's 6/17/15 DSR indicated on 6/17/15 client B was involved in verbal altercations with multiple clients in the morning hours and "was verbally redirected when she continued calling a client a b----" and on "6/17/15 from 7am-3:00pm, The other client threw a water bottle and hit [client B] in the head. [Client B] grabbed the other client by the hair and pushed her body against back of the staff member standing between them...She attempted to hit the client (client A)."</p> <p>3. For client B: -A 4/29/15 BDDS report for an incident on 4/28/15 at 5:10pm indicated client B returned from a psychiatric appointment "agitated that she was having a med (medication) increase. Shortly later, she was prompted by staff to turn her music down." The report indicated client B "responded by flipping the living room table and charging the staff." The report indicated client B "eloped out the front door where staff watched her from the front porch. Staff watched [client B] go</p>			

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	<p>to the neighbor's house on both sides of the group home, knocking on their doors, staff had client in sight from the group home front porch. Finally, a person answered the door to one of the houses and [client B] went inside where staff lost sight of her. At that time, [the PD/QIDP] was notified. Client returned to the group home site within 2 minutes stating she called her sister." The report indicated client B told the PD/QIDP that the staff on duty at the group home had "pushed [client B] and that was why she had to go call her sister...Plan to resolve...Client's plan to be changed to include that of Elopement."</p> <p>On 6/24/15 at 2:40pm and on 6/25/15 at 8:25am, client B's record was reviewed. Client B's 9/2014 BSP did not include elopement behaviors. An additional non approved HRC (Human Rights Committee) 4/28/15 BSP and 4/28/15 ISP included elopement behavior on the list of targeted behaviors and did not include interventions staff should use and did not include a written description of client B's elopement behavior.</p> <p>An interview was conducted with PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) on 6/25/15 at 10:15 AM. PD/QIDP indicated client B's BSP should include</p>			

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	<p>specific instructions and/or interventions regarding what staff should do when client B elopes. The PD/QIDP indicated client B should be supervised by facility staff twenty-four hours a day seven days a week. The PD/QIDP indicated client B's record did not indicate when staff should utilize police or other emergency service personnel to intervene regarding client B's elopement behaviors.</p> <p>4. For client C: -A 5/15/15 BDDS report for an incident on 5/14/15 at 5:50 PM indicated, "At 5:50 PM, the PD (Program Director) was notified that [client C] had left the premises of the group home walking on the sidewalk. [The PD] informed the staff they would arrive to (sic) the site in 25-30 minutes to assist. Staff reported they stayed with the [client C], walking down the street sidewalk of the group home, continuing to follow and attempt(ing) to redirect [client C] when [client C] turned onto [road] a busy street. At that time, [client C] stepped off the sidewalk and into the street, back and forth numerous times in an unsafe manner. The staff was able to guide [client C] back onto the sidewalk each time, however, felt that [client C] was attempting to harm themselves (sic) so the staff member called 911. Police intercepted the client when she was</p>			

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	<p>walking on [street] near [street]. Police called the group home, requesting the second staff member, working that night and attending to the other clients, pick [client C] and the first staff member up from their position. The second staff member gathered up the clients she was caring for, placed them into the van and picked up the did so (sic). [PD #1] arrived to (sic) the site at 6:20 PM to find that [client C] had been brought back to the site by staff who picked her up from police and the first staff member's care."</p> <p>-A 4/13/15 BDDS report for an incident on 4/12/15 at 10:45 PM indicated, "[HM (Home Manager)] called (the) on-call [PD] to report that [client C] had walked away from the group home. Staff called 911 for additional supports and when staff hung up the phone, [client C] was back at the group home. [Client C] was out of staff's sight for 2 minutes before returning back to (the) group home."</p> <p>-A 3/7/15 BDDS report indicated, "At 6:45 PM, [PD] was notified by staff that 911 had been called from the group home due to [client C's] physical aggression toward staff. Prior to the 911 call, staff prompted [client C] to pick up the piles of clothes all around her bed and start washing them or hanging them up if they were clean. [Client C] started to yell</p>			

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	<p>loudly that she was not going to clean up her room. The staff then started picking up the clothes that smelled of urine and started to walk out of her room to the washing machine. At that time and just as the staff member was exiting [client C's] room, [client C] put both of her hands on the staff, proceeded to punch her with both closed fists multiple times. The second staff then ran down the hall to [client C's] room and attempted to put herself in between [client C] and the staff member getting hit but [client C] kept reaching around her and punching the first staff member whom was on the bedroom floor. The second staff member continued to use two hand blocks to keep both staff safe. Sometime during this altercation another client in the home proceeded to call 911 of their own accord. [Client C] continued physical aggression until shortly before the police showed up to the group home about 5 minutes after she hit staff the first time. [Client C] was questioned by the police, told to stop her behavior and the police left. As soon as they left, [client C] started threatening to harm herself, yelling and pacing the home without ceasing for 20 minutes straight. During those 20 minutes she was reaching for items, saying she was going to cut herself. At that time, staff felt they could not keep themselves nor [client C's]</p>			

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	<p>housemates safe, so staff called 911 again. Upon the arrival of police for the second time, [client C] was taken to [hospital]."</p> <p>Client C's record was reviewed on 6/24/15 at 2:00 PM. Client C's 9/20/14 BSP indicated the following:</p> <p>-"Response Measures- SIB. If staff observed [client C] engaging in SIB, request that she stop the behavior. If she stops the SIB, thank her. Request that [client C] then engage in a leisure activity or utilize her coloring sheets. If [client C] would like to talk with staff, staff should allow [client C] time to discuss her concern or frustration. If [Client C] continues the behavior after being requested to stop and the behavior is not causing her physical harm, i.e. scratching at skin without breaking skin, pinching herself etc., ignore the behavior but not [client C]. Continue to monitor [client C] for the SIB to escalate. Request that [client C] engage in another activity with you. It is important that she engage with staff at this time. Staff should color with her, go for a walk, play a game etc. with [client C]. If steps above are unsuccessful and the SIB is a threat to [client C's] safety, use the least amount of agency approved physical intervention (PIA) to stop the SIB. Inform the PD (or) PD</p>			

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	<p>on-call." The review did not indicate documentation of when staff should utilize police or other emergency service personnel to intervene regarding client C's SIB.</p> <p>-"Aggressive Outburst: (1.) Immediately request that [client C] cease the behavior. Request that she calm herself down. Inform [client C] that once she is calm, you will spend time with her talking about what is upsetting her. Allow her to tell you what she is upset about. All you need to do is listen to her. When she has finished encourage her and engage with her in an activity such as coloring, exercise or playing a game; (2.) If the behavior continues and is directed toward other person in the environment, ask them to leave the area for their own safety. Prompt [client C] to engage in a calming activity; (3.) Do not touch [client C] but tell her she will be okay, ask her what you can do to assist her with calming down; (4.) If [client C] is unable or unwilling to calm down or if the outburst is a danger to self or others proceed to step 5; (5.) Direct [client C] to discontinue the behavior immediately; (6.) If the aggressive outburst continues and is a risk of injury to self or others use the agency approved minimum amount of physical guidance necessary to stop the behavior. Use the techniques taught by</p>			

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	<p>Indiana Mentor (PIA)." The review did not indicate documentation of when staff should utilize police or other emergency service personnel to intervene regarding client C's aggressive outburst/aggression.</p> <p>- "Vacating. Staff should be aware of [client C's] whereabouts at all times. In inclement weather, keep protective clothing for staff and [client C] near the door so that it is easily available if [client C] exits the home. If [client C] elopes from staff, keep her in sight and calmly request that she make a positive choice and return to the home or vehicle with you. (3.) (sic) If [client C] responds, thank her for returning and continue with the activity or outing that was going on previous to her elopement. If [client C] appears upset ask her if she wants to talk about what is bothering her or if she needs time to be alone to calm herself down. (4.) If she refuses to return, calmly request again that she return to the location that she eloped from. Continue to follow her but do not make a big deal out of it, do not discuss the situation further. Give [client C] time to think about it (15 minutes) while you are following her and monitoring for safety. (5.) If [client C] refuses after 15 minutes to return, offer her another opportunity to return, if she continues to refuse after this offer, contact the PD or PD on-call for</p>			

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	<p>further instructions." The review did not indicate documentation of when staff should utilize police or other emergency service personnel to intervene regarding client C's elopement behaviors.</p> <p>Client C's 5/4/15 "Risk Management Plan" indicated client C did not "associate consequences with actions, [client C] receives 24/7 (twenty-four hours and day seven days a week) staff support and supervision...[client C] is impulsive and can be defiant...[client C] will not be unattended in the community...law enforcement may get involved due to elopement."</p> <p>An interview was conducted with PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) on 6/25/15 at 10:15 AM. PD/QIDP indicated client C's BSP should include specific instructions or interventions regarding when staff should utilize police or other emergency service personnel to intervene regarding client C's SIB, physical aggression or elopement behaviors. PD/QIDP indicated client C's police involvement component was indicated on client C's Risk Plan. The PD/QIDP indicated client C's BSP should specify how staff are to address client C's elopement behaviors.</p>			

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W 0249 Bldg. 00	<p>This federal tag relates to complaint #IN00176248.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on record review and interview for 3 of 3 sampled clients (clients A, B, and C), the facility failed to use formal and informal opportunities to implement client A, B, and C's ISP (Individual Support Plan) and BSP (Behavior Support Plan) when opportunities existed and failed to use consistent approaches during physically aggressive behaviors and elopement behaviors.</p> <p>Findings include:</p> <p>1. On 6/24/15 at 11:00am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed. The review indicated the following for client A:</p> <p>-A 6/18/15 BDDS report for an incident</p>	W 0249	<p>Client A Behavior Support Plan has been updated to include the use of Physical Intervention Alternative (PIA) techniques and what specific techniques to use with Client A to prevent future elopement behaviors. Client A Individual Support Plan (ISP) and Risk Plans have been updated to include changes made regarding PIA in Client A Behavior Support Plan.</p> <p>All direct care staff will receive retraining on the changes made to Client A Behavior Support plan regarding the specific PIA techniques to use with Client A to prevent future elopement behaviors.</p> <p>The QIDP will complete an audit of all other consumers Behavior Support Plans to ensure that if the use of PIA is recommended</p>	07/17/2015

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	<p>on 6/17/15 at 6:00pm indicated "On Wednesday, June 17, 2015 at 5:52pm" the Residential Manager (RM) notified the Qualified Intellectual Disabilities Professional/Program Director (QIDP/PD) that client A "had eloped from her Indiana Mentor Group Home. Of the two staff on shift, one staff was on an outing with other clients in the Group Home and one was behind with the client that eloped (client A) and a few other clients." The report indicated client A eloped and "the one staff member (at the group home) walked to the end of the driveway and watched the client while talking to [the RM]...eventually reporting she could no longer see the client." The report indicated client A arrived at a different all male group home "approximately a 1/2 (half) hour (sic) later; staff was unable to ascertain how she got there...[client A] refused to go back to her Group Home. Police were called and when they arrived, they told the client she had the right to elope and because she was not a threat of harm to herself or those around her, they would leave. Prior to leaving, they (the Police) told [client A] she should go back home which was approximately 7:00pm. [Client A] got into the Group Home van, cursing at staff, stating she was going to run away again as soon as she got there (back to her Group Home). [Client A]</p>		<p>for use to prevent targeted behaviors that specifics of what techniques are recommended are outlined in consumers Behavior Support Plans. If PIA is identified in consumers Behavior Support Plans the QIDP will update the consumers ISP and Risk plans to reflect any changes.</p> <p>QIDP will receive retraining to include ensuring that if use of PIA techniques is recommended to prevent targeted behaviors that the specific of what techniques to use are outlined in consumers Behavior Support Plans, ISP and Risk plans.</p> <p>Client B BSP has been updated to include the target behavior of elopement, including a description of Client B elopement behavior and has identified client specific strategies for staff to use to prevent future elopement behaviors.</p> <p>QIDP will receive retraining to include ensuring that all consumers Behavior Support Plans include all identified targeted behaviors and also include strategies for how staff are to address targeted behaviors and prevent future occurrences. A review of all consumers Behavior Support plans will be done to ensure all targeted behaviors are identified in the plans and strategies for how staff</p>	

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	<p>arrived to (her Group Home) shortly before 8:00pm, still cursing at staff, laughing hysterically, and threatening to run. Both the staff on shift kept [client A] within their sight because of [client A's] threats." The report indicated client A took her 8:00pm medications and "Afterwards, [client A] told the staff to stop following her and then she started to use closed fist punches to one staff member whom was blocking [client A's] way to an exit door. The staff member attempted to use the one arm hold...The second staff was attempting to stop two other clients whom were threatening to elope at the same time. The first staff member released [client A's] arm and [client A] ran out of the home. At that time the [Residential Manager (RM)] was already parked in her car in front of the [Group Home] reporting to the [PD (Program Director)] that [client A] was threatening to leave when [client A] did just that...The [RM] turned her car on and followed [client A] down the street and into the apartment complex nearby where [the RM] lost sight of [client A]." The report indicated the RM and the PD "drove around for a few minutes," could not locate client A, and called the Police. The report indicated "the time [client A] eloped was approximately 8:37pm. At this time, [client A] has still not been located by the Police nor Mentor staff</p>		<p>should address and prevent targeted behaviors.</p> <p>Client C's BSP has been updated to include specific instructions for when staff are to utilize the police or other emergency service personnel to intervene regarding Client C SIB, Physical aggression and/or elopement behaviors.</p> <p>QIDP will receive retraining to include ensuring that all consumers Behavior Support Plans are comprehensive and identify strategies for how to prevent future occurrences. A review of all consumers Behavior Support plans will be done to ensure all targeted behaviors are identified in the plans and strategies for how staff should address and prevent targeted behaviors.</p> <p>Area Director will complete an audit of all consumers Behavior Support Plans, ISPs and Risk plans to ensure that specifics of what PIA techniques to use to prevent consumers targeted behaviors and when police or emergency personnel are to be called to intervene with behaviors are specifically outlined in consumers Behavior Support Plans, ISPs and risk plans as needed.</p> <p>For the next three months, the Area Director will review all</p>	

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	<p>assisting in looking for [client A]...."</p> <p>Summary of Internal Investigative Report dated 6/22/15 indicated the following: -"Brief Summary of incident: On 6/17/15 at 5:52pm, [client A] eloped from the home, was located by staff and returned to the group home. [Client A] eloped a second time after 8pm and was unable to be located. A report was filed with the [Name of Police Agency]."</p> <p>-The investigation indicated those interviewed were three direct care staff, the Residential Manager, and the Program Director. The investigation was not thorough in that the investigation did not indicate completed interviews with clients who were present at the time of each elopement.</p> <p>-"Background of client and their placement...(Client A's diagnoses included but were not limited to:) Mild Intellectual Disability, Traumatic Brain Injury with behavior disturbance, ADHD (Attention Deficit Hyperactivity Disorder), Seizure DO (Disorder)... [Client A's] history of elopement started prior to her placement at Indiana Mentor, [client A's] ISP and Risk Plan states she experiences Panic Attacks. On 9/2/14 [client A] was missing for over 12 hours and was found in the bed of a client after</p>		<p>changes or annual updates made to any consumers Behavior Support plans completed by the QIDP to ensure that specific PIA techniques recommended to use to prevent consumers targeted behaviors and when staff are to utilize emergency personnel to intervene with behaviors is specifically outlined in their BSP, ISP and Risk plans.</p> <p>Ongoing after the three months, the Area Director will complete a random audit of a minimum of 2 consumers per month BSP, ISP and Risk plans developed by the QIDP to ensure that specific PIA techniques recommended to use to prevent consumers targeted behaviors and when staff are to utilize emergency personnel to intervene with behaviors is specifically outlined in their BSP, ISP and Risk plans.</p> <p>Responsible Party: Home Manager, QIDP, Regional Quality Assurance Specialist, Area Director.</p>	

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	<p>entering his home through a window without staff knowledge...[Client A's] mother became her legal guardian on 7/21/14."</p> <p>-"Interview" with the RM indicated she followed client A in her car during client A's second elopement (6/17/15 at 8:37pm) "...when [client A] reached [name of street] [Client A] attempted to dart into traffic so [the RM] used her car to block [client A] from getting hit by other cars as [the RM] pleaded for [client A] to get in [the RM's] car." The RM indicated she followed client A until she entered the apartment complex where the RM lost sight of client A.</p> <p>-"Interview" with Group Home Staff (GHS) #1 indicated she had picked up client A from day services, returned to the group home, and client A had called her mother and family members without making contact on the telephone. GHS #1 indicated client A became upset and "she [client A] was leaving and ran out the door...[GHS #1] was by herself with clients...she was able to see [client A] from the end of the driveway until [client A] ducked behind the school...[GHS #1] received call from the [RM] to meet at [the second group home]...[client A] was out of control (when GHS #1 arrived at the second group home)...[GHS #1] said</p>				

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	<p>[client A] finally agreed to get in the van, but said she was going to run away again when she got home. [GHS #1] said on the way home [client A] was asked to show them (the staff) where [client A] had knocked on the door and got a ride to [the second group home]. [GHS #1] said [client A] said she knocked on the door, cried, saying she was lost, and needed a ride to [name of second group home]...."</p> <p>-"Interview" with GHS #2 indicated she was out shopping with client E, returned in the van to the group home to find GHS #1 standing in the driveway looking for client A. GHS #2 "said when [client A] returned home she was treated like a rock star by her housemates. [GHS #2] said [client A] was being congratulated, high fived, and generally encouraged for running away. [GHS #2] said there was a lot of commotion and the noise level was high...[Client A] continued to threaten to leave. Attempts to calm [client A] were not successful. [GHS #2] said at about 8:30pm, [client A] ran out the front door and all her housemates ran to the front of the house and cheered her on."</p> <p>-"Interview" with the PD (Program Director) indicated "...On 6/22/15 she received a call from [GHS #7] a [substitute staff at the group home] the morning of 6/20/15 (Saturday). [PD]</p>			

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	<p>said [GHS #7] informed her that the police had [client A] at 34th (Street) and Meridian St. and was being taken to [Name of Hospital] for evaluation. [PD] said she met [client A] at the emergency room. [PD] said she had only a few minutes alone with [client A] before [client A's] mother arrived. [PD] said [client A] stated she made \$60.00 for sex, but then was forced to take drugs and was passed around for sex, which she did not like. [PD] said [client A's] mother took [client A] home following the forensic evaluation. [PD] said she has applied for the Project Lifesaver (electronic monitoring device), which would not be available for up to two months due to availability."</p> <p>-"Interview" with client A's mother/guardian indicated client A's mother/guardian had been driving to Indianapolis from [name of city] in an attempt to locate client A on the street. Client A's mother/guardian indicated she was tracing telephone calls made by client A when client A called family members out of town and had traced client A who was using other people's cell phones which she had borrowed on the street and a pay phone at a bus stop. Client A's mother/guardian indicated she was at the hospital with client A on 6/20/15 after being notified that client A</p>			

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	<p>had been found. Client A's mother/guardian indicated client A "told her she (client A) did make \$60.00 from a man who then started pimping [client A] out...(client A) was forced to consume drugs and was passed from person to person including a women for sex...when [client A] told them to stop she was told to get her things and get out...(client A) tested positive for cocaine, opiates, and THC (Tetrahydrocannabinol, a chemical responsible for most of marijuana's psychological effects)...(client A) is experiencing pain with rectal and vaginal bleeding...(Client A) is having panic attacks and nightmares...." Client A's mother/guardian stated "she intends to keep [client A] home until the Project Life Saver can be put into place."</p> <p>-"Conclusion" indicated client A eloped twice on the evening of 6/17/15. Evidence supports physical intervention was not used in order to keep client A from leaving the group home. The investigation was not thorough in that it did not document witness statements from other clients present in the home and during both elopements of client A. The investigation did not indicate recommendations and corrective actions to protect client A and to protect other clients from their identified behaviors. The investigation did not indicate</p>			

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	<p>documentation of staff implementing client A's BSP, ISP, or the effectiveness of PIA (Physical Intervention Alternatives) techniques to prevent the incident from escalating from client A's elopement behaviors.</p> <p>Client A's 6/20/15 Hospital Emergency Room Record was reviewed on 6/24/15 at 8:30am. The hospital record "Emergency Room" documentation by the physician indicated "Pt. (Patient) reports that she ran away from group home 3 days ago. She reports she met a man who offered her money, made her smoke spice and marijuana, snorted cocaine. She reports she was sexually assaulted by upward of 7 different men over that time on separate occasions. She reports vaginal, anal, and oral penetration...inflamed skin external genitalia...Assessment: Sexual Assault, medically stable...+ (positive) for cocaine / opiates...pelvic done/evidence collected...given counseling sources... (signed by the physician)." The 6/20/15 "ER Triage Chief Complaint...Drug Abuse, possible Sexual Assault of adult." Client A's 6/20/15 "EMS (Emergency Medical Services) Incident" document indicated "9-1-1 dispatched for injured person...found 19 yo/w/f (year old/white/female) ambulatory on scene with [Police]. [Police] stated that pt.</p>			

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	<p>(patient) was found laying on the ground in the doorway of a hallway to an apartment building with many bystanders around. [Client A] told [Police] that she walked away from her group home (and she stays there due to a previous brain injury. On June 17th and (sic) was picked up by a couple of guys. According to [Police], after that the men gave her crack cocaine, pt. states she snorted and smoked it and (they) physically sexually assaulted her. Pt. claims to have not slept since Tuesday and last used crack cocaine about 20 minutes prior to being found by [Police]. Her only complaint was that her face was numb, she was having tingling in her upper extremities, and she was sleepy from having not slept since Tuesday. [Police] notified representatives from her group home enroute to [name of hospital]. [Client A] started to feel nauseous but did not vomit until we started to pull into the ambulance bay at [name of hospital]...."</p> <p>Confidential Interview (CI) #1 stated on 6/20/15 client A was "filthy dirty," was not wearing client A's personal clothing, was not wearing underwear, was not wearing a bra, and had injuries to her face, chest, and genitalia.</p> <p>CI #2 stated client A "does not</p>			

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	<p>understand consent and could not give consent." CI #2 stated client A had "told (CI #2) that she was passed around from man to man and some women" for sex. CI #2 indicated client A told her she left the group home the second time on 6/17/15, hitchhiked to [name of neighborhood], walked the streets, met the man who told client A she was pretty, and that he could show client A how to make money. CI #2 indicated client A told CI #2 that the man had sex with client A multiple times, passed her to other men and women for sex to exchange for money, lived on the streets of Indianapolis, consumed cocaine, marijuana, and opiates. CI #2 indicated on Saturday, 6/20/15 client A said she was asked to step outside an apartment during a visit to a new location with the unknown man, client A stepped outside the apartment in the doorway, sat down, fell asleep, and woke up with the Police Officers looking at her.</p> <p>Client A's record was reviewed on 6/24/15 at 11:50am.</p> <p>-Client A's 5/4/15 ISP indicated client A had "targeted behaviors" which included: Panic Attacks, Inappropriate interaction with males, and vacating (elopement) behaviors. Client A's ISP indicated she had elopement behaviors 9/2/14 when client A "was discovered to have eloped</p>			

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	<p>from her group home. She was found on 9/3/14 at 8:15am at a [name of group home] that of her alleged boyfriend... [Client A] had consensual sex with her alleged boyfriend and also went to sleep next to him during the night...9/24/14 [client A] was found under her bedroom covers with two other clients whom alleged that sexual misconduct had taken place in the form of her (female) housemate touching her in the breast and vagina area. The allegation could not be substantiated...10/18/14 at 8:00pm, [client A] successfully eloped from the group home and was later found at her (different) boyfriend's [name of group home] at 8:28pm. She willingly transported back to her group home but threatened to elope again...2/17/15 stayed in a hotel all night and day with her (different) boyfriend while on a home visit in [name of city]...." Client A's ISP did not include proactive measures and objectives to teach client A protective measures regarding personal safety, elopement, and safety skills. Client A's ISP indicated she required twenty-four hour a day staff supervision.</p> <p>-Client A's 10/18/14, 9/24/14, and 9/2/14 IDT (Interdisciplinary Team) meeting notes indicated "1:1 (One on One) staff supervision" was implemented after each incident of elopement and did not</p>			

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	<p>indicate when the one on one staff supervision was changed.</p> <p>-Client A's 5/4/2015 "Risk Management Assessment and Plan" indicated client A "Presents a risk" for the following areas of assessment: "Wears glasses...Some balance issues due to her left leg being somewhat shorter than her right, walks with a limp...slight weakness in her hand...is not able to administer medications independently...panic attacks...(does not) associate consequences with actions [client A] has a history of inappropriate interactions with males as well as placing herself in potentially dangerous situations in her interactions with males. Would benefit from 24/7 supervision to ensure her health and safety and general welfare... (does not) inform support person (the staff) of plans when leaving home area. [Client A] has history of elopement...would readily get into a car with a man she does not know if he paid attention to her...(does not) exhibit socially accepted behaviors in public... (does not) have ability to remain alone in any environment. [Client A] lacks the ability to do this independently...Would not likely defend herself...may not be able to recognize what is considered abuse and therefore not report appropriately...[Client A] needs</p>			

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	<p>assistance with her finances...has a history of cutting herself...[Client A] requires 24 hour awake supervision."</p> <p>-Client A's 2/2014 BSP indicated identified targeted behaviors of Panic Attack, Inappropriate with males, and vacating (elopement). Client A's BSP indicated "Vacating...Staff should be aware of [client A's] whereabouts at all times...If [client A] elopes from staff, keep her in sight and calmly request that she make a positive choice, and return to the home or vehicle with you...If [client A] appears upset ask her if she wants to talk about what is bothering her, or if she needs time to be alone to calm herself down. If she refuses to return, calmly request again that she return to the location that she eloped from. Continue to follow her, but do not make a big deal out of it, do not discuss the situation further. Give [client A] time to think about it, 15 min. (minutes), while you are following her and monitoring for safety. If [client A] refuses after 15 minutes to return, offer her another opportunity to return, if she continues to refuse after this offer, contact the PD (Program Director) or PD (Program Director) on call for further instruction, do not inform [client A] that you are contacting the PD, do not make a fuss or a big deal about contacting the PD. If [client A's]</p>			

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	<p>elopement has put her in a potentially dangerous situation in a high traffic area, implement least restrictive agency approved physical intervention (PIA) to maintain safety. If possible a staff member that is not actively intervening with [client A] contact the PD...." Client A's BSP did not include the agency's definition for PIA.</p> <p>On 6/24/15 at 12:30pm, the facility's undated "Physical Intervention Alternatives" policy and procedure located in the staff communication book for "Physical restraint: All Indiana Mentor staff are trained upon employment and re-trained annually on these procedures. Any escorts/restraints should be released as quickly as possible. If a restraint lasts for 10 minutes, the client should be released and staff should attempt blocking/avoidance unless it is unsafe to do so. If blocking/avoidance continues to be ineffective or unsafe, reinstate physical restraint for 10 minute intervals attempting to release the client when it is safe to do so. If a client does not respond to proactive measures or non-restrictive measures use restrictive company approved PIA (Physical Intervention Alternatives) techniques listed in this order: Physical restraints should be used only when physical aggression will likely result in harm to</p>			

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	<p>oneself, others, or when property destruction might affect peoples' health and safety otherwise use blocking/avoidance. Staff may skip less restrictive measure only if health/safety is an imminent threat. Escorts: Side by side escort walking slightly behind and to the side of the person. Hand below elbow 'L' shaped hand cupping the elbow. Hand behind elbow and hand mid-back. Restraints only to be used if blocking, avoidance or escort is not safe. One arm hold uses 'L' shaped hand to restrict one of the client's arms. Two arm hold, same as one arm but uses second arm to restrain client's flailing arm to the side still only restraining one arm. One arm hold to the floor-client in sitting position. Floor hold (two person) use one arm to the floor restraint, second staff used to restrain legs of the client."</p> <p>On 6/24/15 at 10:30am, an interview was conducted with the QIDP/PD. The QIDP/PD stated client A did not recognize danger, "required" twenty-four hour staff supervision, and had eloped from the group home on 6/17/15. The QIDP/PD indicated client A's ISP, BSP, and risk plans should have been implemented on 6/17/15. The QIDP/PD stated she was filling out the paperwork for the application of client A's Protect Life Saver program and indicated after</p>			

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	<p>the application was submitted it "would be at least two months or longer" before client A would be available for the program. When asked what protective measures and corrective actions had been developed after client A's continued elopement behaviors, the QIDP/PD stated "We added one on one staff" supervision. When asked why client A did not have one on one staff supervision on 6/17/15, the QIDP/PD indicated there were two (2) staff in the home on the schedule and one of the two was gone with client E on a community outing which left one staff alone with seven (7) clients. The QIDP/PD indicated there were three (3) additional clients living in the group home who were elopement risks. The QIDP/PD stated she was "unsure" when client A's one on one staff supervision was discontinued. The QIDP/PD stated client A "did not recognize danger," "required staff supervision," and was "unsafe" when she runs into traffic on the streets during elopements on 6/17/15.</p> <p>2. On 6/25/15 at 10:15 AM, an interview with the QIDP/PD was conducted. The QIDP/PD stated she was made aware of an incident on 6/17/15 before client A had left on her elopement "the first time." The QIDP/PD stated she was in the process of starting an investigation into</p>			

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	<p>that event when client A left on elopement the first time, then left on the second elopement, and was "attempting to locate" client A in the community. The QIDP/PD stated she "failed to report to BDDS and failed to investigate" client A's original incident documented in her DSR (Daily Service Record). The QIDP/PD provided an incomplete investigation summary which indicated "Date/Time of Incident: 6/17/15 10:04am...Brief Summary of Incident: [client A] and [client B] had a physical altercation while in the van as the home was preparing to exit for morning transport." The investigation indicated the House Manager had indicated to the QIDP/PD that she would "give the details later" of what occurred and indicated client A had left the group home "and did not return" to the group home.</p> <p>On 6/25/15 at 10:15am, the QIDP/PD provided a review of client A and B's DSRs: -Client A's 6/17/15 DSR indicated on "6/17/15 from 7am-3pm, Housemates began to argue. Staff verbally intervened. [Client A] picked up a water bottle and threw it at her housemate [client B], hitting [client B] in the head. Staff was between the two clients attempting to keep distance between them, the housemate [client B] with the water</p>			

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	<p>bottle pushed staff toward and grabbed [client A] by the hair. Staff was getting hit from behind in the back and shoulder as [client B] attempted to punch [client A]. Staff used PIA (Physical Intervention Alternatives) during the altercation to release housemates hand from the hair grab. [Client A] was bent down and staff saw her glasses come off and fall to the floor. During this moment staff heard the back door open and housemate [client B] was no longer against staffs back. [Client A] began yelling and exited the van through the front passenger door. [Client A] was out of the van for several minutes with another staff when [client A] returned she was calm."</p> <p>-Client B's 6/17/15 DSR indicated on 6/17/15 client B was involved in verbal altercations with multiple clients in the morning hours and "was verbally redirected when she continued calling a client a b----" and on "6/17/15 from 7am-3:00pm, The other client threw a water bottle and hit [client B] in the head. [Client B] grabbed the other client by the hair and pushed her body against back of the staff member standing between them...She attempted to hit the client (client A)."</p> <p>3. For client B: -A 4/29/15 BDDS report for an incident</p>			

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	<p>on 4/28/15 at 5:10pm indicated client B returned from a psychiatric appointment "agitated that she was having a med (medication) increase. Shortly later, she was prompted by staff to turn her music down." The report indicated client B "responded by flipping the living room table and charging the staff." The report indicated client B "eloped out the front door where staff watched her from the front porch. Staff watched [client B] go to the neighbor's house on both sides of the group home, knocking on their doors, staff had client in sight from the group home front porch. Finally, a person answered the door to one of the houses and [client B] went inside where staff lost sight of her. At that time, [the PD/QIDP] was notified. Client returned to the group home site within 2 minutes stating she called her sister." The report indicated client B told the PD/QIDP that the staff on duty at the group home had "pushed [client B] and that was why she had to go call her sister...Plan to resolve...Client's plan to be changed to include that of Elopement."</p> <p>On 6/24/15 at 2:40pm and on 6/25/15 at 8:25am, client B's record was reviewed. Client B's 9/2014 BSP did not include elopement behaviors. An additional non approved HRC (Human Rights Committee) 4/28/15 BSP and 4/28/15</p>			

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	<p>ISP included elopement behavior on the list of targeted behaviors and did not include interventions staff should use and did not include a written description of client B's elopement behavior.</p> <p>An interview was conducted with PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) on 6/25/15 at 10:15 AM. The PD/QIDP indicated client B's BSP should include specific instructions and/or interventions regarding what staff should do when client B elopes. The PD/QIDP indicated client B should be supervised by facility staff twenty-four hours a day seven days a week.</p> <p>4. For client C: -A 5/15/15 BDDS report for an incident on 5/14/15 at 5:50 PM indicated, "At 5:50 PM, the PD (Program Director) was notified that [client C] had left the premises of the group home walking on the sidewalk. [The PD] informed the staff they would arrive to (sic) the site in 25-30 minutes to assist. Staff reported they stayed with the [client C], walking down the street sidewalk of the group home, continuing to follow and attempt(ing) to redirect [client C] when [client C] turned onto [road] a busy street. At that time, [client C] stepped off the sidewalk and into the street, back and</p>			

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	<p>forth numerous times in an unsafe manner. The staff was able to guide [client C] back onto the sidewalk each time, however, felt that [client C] was attempting to harm themselves (sic) so the staff member called 911. Police intercepted the client when she was walking on [street] near [street]. Police called the group home, requesting the second staff member, working that night and attending to the other clients, pick [client C] and the first staff member up from their position. The second staff member gathered up the clients she was caring for, placed them into the van and picked up the did so (sic). [PD #1] arrived to (sic) the site at 6:20 PM to find that [client C] had been brought back to the site by staff who picked her up from police and the first staff member's care."</p> <p>-A 4/13/15 BDDS report for an incident on 4/12/15 at 10:45 PM indicated, "[HM (Home Manager)] called (the) on-call [PD] to report that [client C] had walked away from the group home. Staff called 911 for additional supports and when staff hung up the phone, [client C] was back at the group home. [Client C] was out of staff's sight for 2 minutes before returning back to (the) group home."</p> <p>-A 3/7/15 BDDS report indicated, "At 6:45 PM, [PD] was notified by staff that</p>			

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	<p>911 had been called from the group home due to [client C's] physical aggression toward staff. Prior to the 911 call, staff prompted [client C] to pick up the piles of clothes all around her bed and start washing them or hanging them up if they were clean. [Client C] started to yell loudly that she was not going to clean up her room. The staff then started picking up the clothes that smelled of urine and started to walk out of her room to the washing machine. At that time and just as the staff member was exiting [client C's] room, [client C] put both of her hands on the staff, proceeded to punch her with both closed fists multiple times. The second staff then ran down the hall to [client C's] room and attempted to put herself in between [client C] and the staff member getting hit but [client C] kept reaching around her and punching the first staff member whom was on the bedroom floor. The second staff member continued to use two hand blocks to keep both staff safe. Sometime during this altercation another client in the home proceeded to call 911 of their own accord. [Client C] continued physical aggression until shortly before the police showed up to the group home about 5 minutes after she hit staff the first time. [Client C] was questioned by the police, told to stop her behavior and the police left. As soon as they left, [client C]</p>			

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	<p>started threatening to harm herself, yelling and pacing the home without ceasing for 20 minutes straight. During those 20 minutes she was reaching for items, saying she was going to cut herself. At that time, staff felt they could not keep themselves nor [client C's] housemates safe, so staff called 911 again. Upon the arrival of police for the second time, [client C] was taken to [hospital]."</p> <p>Client C's record was reviewed on 6/24/15 at 2:00 PM. Client C's 9/20/14 BSP indicated the following:</p> <p>-"Response Measures- SIB. If staff observed [client C] engaging in SIB, request that she stop the behavior. If she stops the SIB, thank her. Request that [client C] then engage in a leisure activity or utilize her coloring sheets. If [client C] would like to talk with staff, staff should allow [client C] time to discuss her concern or frustration. If [Client C] continues the behavior after being requested to stop and the behavior is not causing her physical harm, i.e. scratching at skin without breaking skin, pinching herself etc., ignore the behavior but not [client C]. Continue to monitor [client C] for the SIB to escalate. Request that [client C] engage in another activity with you. It is important that she engage with</p>			

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	<p>staff at this time. Staff should color with her, go for a walk, play a game etc. with [client C]. If steps above are unsuccessful and the SIB is a threat to [client C's] safety, use the least amount of agency approved physical intervention (PIA) to stop the SIB. Inform the PD (or) PD on-call." The review did not indicate documentation of when staff should utilize police or other emergency service personnel to intervene regarding client C's SIB.</p> <p>-"Aggressive Outburst: (1.) Immediately request that [client C] cease the behavior. Request that she calm herself down. Inform [client C] that once she is calm, you will spend time with her talking about what is upsetting her. Allow her to tell you what she is upset about. All you need to do is listen to her. When she has finished encourage her and engage with her in an activity such as coloring, exercise or playing a game; (2.) If the behavior continues and is directed toward other person in the environment, ask them to leave the area for their own safety. Prompt [client C] to engage in a calming activity; (3.) Do not touch [client C] but tell her she will be okay, ask her what you can do to assist her with calming down; (4.) If [client C] is unable or unwilling to calm down or if the outburst is a danger to self or others</p>			

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	<p>proceed to step 5; (5.) Direct [client C] to discontinue the behavior immediately;</p> <p>(6.) If the aggressive outburst continues and is a risk of injury to self or others use the agency approved minimum amount of physical guidance necessary to stop the behavior. Use the techniques taught by Indiana Mentor (PIA)." The review did not indicate documentation of when staff should utilize police or other emergency service personnel to intervene regarding client C's aggressive outburst/aggression.</p> <p>-"Vacating. Staff should be aware of [client C's] whereabouts at all times. In inclement weather, keep protective clothing for staff and [client C] near the door so that it is easily available if [client C] exits the home. If [client C] elopes from staff, keep her in sight and calmly request that she make a positive choice and return to the home or vehicle with you. (3.) (sic) If [client C] responds, thank her for returning and continue with the activity or outing that was going on previous to her elopement. If [client C] appears upset ask her if she wants to talk about what is bothering her or if she needs time to be alone to calm herself down. (4.) If she refuses to return, calmly request again that she return to the location that she eloped from. Continue to follow her but do not make a big deal out of it, do not discuss the situation</p>			

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	<p>further. Give [client C] time to think about it (15 minutes) while you are following her and monitoring for safety. (5.) If [client C] refuses after 15 minutes to return, offer her another opportunity to return, if she continues to refuse after this offer, contact the PD or PD on-call for further instructions." The review did not indicate documentation of when staff should utilize police or other emergency service personnel to intervene regarding client C's elopement behaviors.</p> <p>Client C's 5/4/15 "Risk Management Plan" indicated client C did not "associates consequences with actions, [client C] receives 24/7 (twenty-four hours and day seven days a week) staff support and supervision...[client C] is impulsive and can be defiant...[client C] will not be unattended in the community...law enforcement may get involved due to elopement."</p> <p>An interview was conducted with PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional) on 6/25/15 at 10:15 AM, PD/QIDP indicated client C's BSP should include specific instructions or interventions regarding when staff should utilize police or other emergency service personnel to intervene regarding client C's SIB, physical aggression or elopement</p>			

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W 0289 Bldg. 00	<p>behaviors. PD/QIDP indicated client C's police involvement component was indicated on client C's Risk Plan.</p> <p>This federal tag relates to complaint #IN00176248.</p> <p>9-3-4(a)</p> <p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on record review, and interview, for 1 of 2 sample clients (client A) who had physical interventions employed for behavior, the facility failed to have a written description in client A's plan for physical behavioral interventions/Physical Intervention Alternatives (PIA) which were used for client A.</p> <p>Findings include:</p> <p>On 6/24/15 at 11:00am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed. The review indicated the following for client A:</p> <p>-A 6/18/15 BDDS report for an incident</p>			W 0289	<p>Client A Behavior Support Plan has been updated to include the use of Physical Intervention Alternative (PIA) techniques and what specific techniques to use with Client A to prevent future elopement behaviors. Client A Individual Support Plan (ISP) and Risk Plans have been updated to include changes made regarding PIA in Client A Behavior Support Plan.</p> <p>All direct care staff will receive retraining on the changes made to Client A Behavior Support plan regarding the specific PIA techniques to use with Client A to prevent future elopement behaviors.</p> <p>The QIDP will complete an audit of all other consumers Behavior</p>		07/17/2015

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	<p>on 6/17/15 at 6:00pm indicated "On Wednesday, June 17, 2015 at 5:52pm" the Residential Manager (RM) notified the Qualified Intellectual Disabilities Professional/Program Director (QIDP/PD) that client A "had eloped from her Indiana Mentor Group Home. Of the two staff on shift, one staff was on an outing with other clients in the Group Home and one was behind with the client that eloped (client A) and a few other clients." The report indicated client A eloped and "the one staff member (at the group home) walked to the end of the driveway and watched the client while talking to [the RM]...eventually reporting she could no longer see the client." The report indicated client A arrived at a different all male group home "approximately a 1/2 (half) hour (sic) later; staff was unable to ascertain how she got there...[client A] refused to go back to her Group Home. Police were called and when they arrived, they told the client she had the right to elope and because she was not a threat of harm to herself or those around her, they would leave. Prior to leaving, they (the Police) told [client A] she should go back home which was approximately 7:00pm. [Client A] got into the Group Home van, cursing at staff, stating she was going to run away again as soon as she got there (back to her Group Home). [Client A]</p>		<p>Support Plans to ensure that if the use of PIA is recommended for use to prevent targeted behaviors that specifics of what techniques are recommended are outlined in consumers Behavior Support Plans. If PIA is identified in consumers Behavior Support Plans the QIDP will update the consumers ISP and Risk plans to reflect any changes.</p> <p>QIDP will receive retraining to include ensuring that if use of PIA techniques is recommended to prevent targeted behaviors that the specific of what techniques to use are outlined in consumers Behavior Support Plans, ISP and Risk plans.</p> <p>Area Director will complete an audit of all consumers Behavior Support Plans, ISPs and Risk plans to ensure that specifics of what PIA techniques to use to prevent consumers targeted behaviors are specifically outlined in consumers Behavior Support Plans, ISPs and risk plans as needed.</p> <p>For the next three months, the Area Director will review all changes or annual updates made to any consumers Behavior Support plans completed by the QIDP to ensure that specific PIA techniques recommended to use to prevent consumers targeted behaviors are specifically outlined in their BSP, ISP and Risk plans.</p>	

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	<p>arrived to (her Group Home) shortly before 8:00pm, still cursing at staff, laughing hysterically, and threatening to run. Both the staff on shift kept [client A] within their sight because of [client A's] threats." The report indicated client A took her 8:00pm medications and "Afterwards, [client A] told the staff to stop following her and then she started to use closed fist punches to one staff member whom was blocking [client A's] way to an exit door. The staff member attempted to use the one arm hold...The second staff was attempting to stop two other clients whom were threatening to elope at the same time. The first staff member released [client A's] arm and [client A] ran out of the home. At that time the [Residential Manager (RM)] was already parked in her car in front of the [Group Home] reporting to the [PD (Program Director)] that [client A] was threatening to leave when [client A] did just that...The [RM] turned her car on and followed [client A] down the street and into the apartment complex nearby where [the RM] lost sight of [client A]." The report indicated the RM and the PD "drove around for a few minutes," could not locate client A, and called the Police. The report indicated "the time [client A] eloped was approximately 8:37pm. At this time, [client A] has still not been located by the Police nor Mentor staff</p>		<p>Ongoing after the three months, the Area Director will complete a random audit of a minimum of 2 consumers per month BSP, ISP and Risk plans developed by the QIDP to ensure that specific PIA techniques recommended to use to prevent consumers targeted behaviors are specifically outlined in their BSP, ISP and Risk plans.</p> <p>Responsible Party: QIDP, Area Director</p>	

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	<p>assisting in looking for [client A]...."</p> <p>Summary of Internal Investigative Report dated 6/22/15 indicated the following: -"Brief Summary of incident: On 6/17/15 at 5:52pm, [client A] eloped from the home, was located by staff and returned to the group home. [Client A] eloped a second time after 8pm and was unable to be located. A report was filed with the [Name of Police Agency]."</p> <p>-"Background of client and their placement...(Client A's diagnoses included but were not limited to:) Mild Intellectual Disability, Traumatic Brain Injury with behavior disturbance, ADHD (Attention Deficit Hyperactivity Disorder), Seizure DO (Disorder)... [Client A's] history of elopement started prior to her placement at Indiana Mentor, [client A's] ISP and Risk Plan states she experiences Panic Attacks. On 9/2/14 [client A] was missing for over 12 hours and was found in the bed of a client after entering his home through a window without staff knowledge...[Client A's] mother became her legal guardian on 7/21/14."</p> <p>-"Interview" with the RM indicated she followed client A in her car during client A's second elopement (6/17/15 at 8:37pm) "...when [client A] reached</p>			

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	<p>[name of street] [Client A] attempted to dart into traffic so [the RM] used her car to block [client A] from getting hit by other cars as [the RM] pleaded for [client A] to get in [the RM's] car." The RM indicated she followed client A until she entered the apartment complex where the RM lost sight of client A.</p> <p>-"Interview" with Group Home Staff (GHS) #1 indicated she had picked up client A from day services, returned to the group home, and client A had called her mother and family members without making contact on the telephone. GHS #1 indicated client A became upset and "she [client A] was leaving and ran out the door...[GHS #1] was by herself with clients...she was able to see [client A] from the end of the driveway until [client A] ducked behind the school...[GHS #1] received call from the [RM] to meet at [the second group home]...[client A] was out of control (when GHS #1 arrived at the second group home)...[GHS #1] said [client A] finally agreed to get in the van, but said she was going to run away again when she got home. [GHS #1] said on the way home [client A] was asked to show them (the staff) where [client A] had knocked on the door and got a ride to [the second group home]. [GHS #1] said [client A] said she knocked on the door, cried, saying she was lost, and needed a</p>			
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	<p>ride to [name of second group home]...."</p> <p>-"Interview" with GHS #2 indicated she was out shopping with client E, returned in the van to the group home to find GHS #1 standing in the driveway looking for client A. GHS #2 "said when [client A] returned home she was treated like a rock star by her housemates. [GHS #2] said [client A] was being congratulated, high fived, and generally encouraged for running away. [GHS #2] said there was a lot of commotion and the noise level was high...[Client A] continued to threaten to leave. Attempts to calm [client A] were not successful. [GHS #2] said at about 8:30pm, [client A] ran out the front door and all her housemates ran to the front of the house and cheered her on."</p> <p>-"Interview" with the PD (Program Director) indicated "...On 6/22/15 she received a call from [GHS #7] a [substitute staff at the group home] the morning of 6/20/15 (Saturday). [PD] said [GHS #7] informed her that the police had [client A] at 34th (Street) and Meridian St. and was being taken to [Name of Hospital] for evaluation. [PD] said she met [client A] at the emergency room. [PD] said she had only a few minutes alone with [client A] before [client A's] mother arrived. [PD] said [client A] stated she made \$60.00 for sex,</p>			

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	<p>but then was forced to take drugs and was passed around for sex, which she did not like. [PD] said [client A's] mother took [client A] home following the forensic evaluation. [PD] said she has applied for the Project Lifesaver (electronic monitoring device), which would not be available for up to two months due to availability."</p> <p>-"Conclusion" indicated client A eloped twice on the evening of 6/17/15. Evidence supports physical intervention was not used in order to keep client A from leaving the group home. The investigation did not indicate documentation of the effectiveness of PIA (Physical Intervention Alternatives) techniques to prevent the incident from escalating from client A's elopement behaviors.</p> <p>CI #2 stated client A "does not understand consent and could not give consent." CI #2 stated client A had "told (CI #2) that she was passed around from man to man and some women" for sex. CI #2 indicated client A told her she left the group home the second time on 6/17/15, hitchhiked to [name of neighborhood], walked the streets, met the man who told client A she was pretty, and that he could show client A how to make money. CI #2 indicated client A</p>			

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	<p>told CI #2 that the man had sex with client A multiple times, passed her to other men and women for sex to exchange for money, lived on the streets of Indianapolis, consumed cocaine, marijuana, and opiates. CI #2 indicated on Saturday, 6/20/15 client A said she was asked to step outside an apartment during a visit to a new location with the unknown man, client A stepped outside the apartment in the doorway, sat down, fell asleep, and woke up with the Police Officers looking at her.</p> <p>Client A's record was reviewed on 6/24/15 at 11:50am.</p> <p>-Client A's 5/4/15 ISP indicated client A had "targeted behaviors" which included: Panic Attacks, Inappropriate interaction with males, and vacating (elopement) behaviors. Client A's ISP indicated she required twenty-four hour a day staff supervision. Client A's Plan did not include the use of PIA.</p> <p>-Client A's 5/4/2015 "Risk Management Assessment and Plan" indicated client A "Presents a risk" for the following areas of assessment: "Wears glasses...Some balance issues due to her left leg being somewhat shorter than her right, walks with a limp...slight weakness in her hand...is not able to administer medications independently...panic</p>			

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	<p>attacks...(does not) associate consequences with actions [client A] has a history of inappropriate interactions with males as well as placing herself in potentially dangerous situations in her interactions with males. Would benefit from 24/7 supervision to ensure her health and safety and general welfare... (does not) inform support person (the staff) of plans when leaving home area. [Client A] has history of elopement...would readily get into a car with a man she does not know if he paid attention to her...(does not) exhibit socially accepted behaviors in public... (does not) have ability to remain alone in any environment. [Client A] lacks the ability to do this independently...Would not likely defend herself...may not be able to recognize what is considered abuse and therefore not report appropriately...[Client A] needs assistance with her finances...has a history of cutting herself...[Client A] requires 24 hour awake supervision."</p> <p>-Client A's 2/2014 BSP indicated identified targeted behaviors of Panic Attack, Inappropriate with males, and vacating (elopement). Client A's BSP indicated "Vacating...Staff should be aware of [client A's] whereabouts at all times...If [client A] elopes from staff, keep her in sight and calmly request that</p>			

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	<p>she make a positive choice, and return to the home or vehicle with you...If [client A] appears upset ask her if she wants to talk about what is bothering her, or if she needs time to be alone to calm herself down. If she refuses to return, calmly request again that she return to the location that she eloped from. Continue to follow her, but do not make a big deal out of it, do not discuss the situation further. Give [client A] time to think about it, 15 min. (minutes), while you are following her and monitoring for safety. If [client A] refuses after 15 minutes to return, offer her another opportunity to return, if she continues to refuse after this offer, contact the PD (Program Director) or PD (Program Director) on call for further instruction, do not inform [client A] that you are contacting the PD, do not make a fuss or a big deal about contacting the PD. If [client A's] elopement has put her in a potentially dangerous situation in a high traffic area, implement least restrictive agency approved physical intervention (PIA) to maintain safety. If possible a staff member that is not actively intervening with [client A] contact the PD...." Client A's BSP did not include the agency's definition for PIA.</p> <p>On 6/24/15 at 12:30pm, the facility's undated "Physical Intervention</p>			

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	<p>Alternatives (PIA)" policy and procedure located in the staff communication book for "Physical restraint: All Indiana Mentor staff are trained upon employment and re-trained annually on these procedures. Any escorts/restraints should be released as quickly as possible. If a restraint lasts for 10 minutes, the client should be released and staff should attempt blocking/avoidance unless it is unsafe to do so. If blocking/avoidance continues to be ineffective or unsafe, reinstate physical restraint for 10 minute intervals attempting to release the client when it is safe to do so. If a client does not respond to proactive measures or non-restrictive measures use restrictive company approved PIA (Physical Intervention Alternatives) techniques listed in this order: Physical restraints should be used only when physical aggression will likely result in harm to oneself, others, or when property destruction might affect peoples' health and safety otherwise use blocking/avoidance. Staff may skip less restrictive measure only if health/safety is an imminent threat. Escorts: Side by side escort walking slightly behind and to the side of the person. Hand below elbow 'L' shaped hand cupping the elbow. Hand behind elbow and hand mid-back. Restraints only to be used if blocking, avoidance or escort is not safe. One arm</p>			

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	<p>hold uses 'L' shaped hand to restrict one of the client's arms. Two arm hold, same as one arm but uses second arm to restrain client's flailing arm to the side still only restraining one arm. One arm hold to the floor-client in sitting position. Floor hold (two person) use one arm to the floor restraint, second staff used to restrain legs of the client." The facility's undated "Hierarchy of Physical Interventions" (PIA) policy indicated "6. Physical restraint (PR) refers to the application of physical force to prevent the person from harming him/herself or others. PR (Physical Restraint) is not a therapeutic technique and is only utilized in emergency situations when everything else has failed. It may only be used for extreme behaviors."</p> <p>On 6/24/15 at 10:30am, an interview was conducted with the QIDP/PD. The QIDP/PD stated client A did not recognize danger, "required" twenty-four hour staff supervision, and had eloped from the group home on 6/17/15. The QIDP/PD indicated client A's ISP, BSP, and risk plans should have been implemented on 6/17/15. The QIDP/PD indicated PIA was used for client A's behaviors and was not defined as a part of her written plan.</p> <p>This federal tag relates to complaint</p>			

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W 0382  Bldg. 00	<p>#IN00176248.</p> <p>9-3-5(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation, record review, and interview, for 1 additional client (client D) who resided in the group home, the facility failed to keep client D's Insulin medication locked when not being administered.</p> <p>Findings include:</p> <p>On 6/26/15 from 6:05am until 7:25am, clients B, C, D, E, F, G, and H were observed at the group home. At 6:25am, client E left the group home on a workshop bus. From 6:05am until 7:18am, GHS (Group Home Staff) #8 was the one staff with clients B, C, D, F, G, and H who accessed each area of the group home independently. At 7:00am, client D removed a black lock box from the refrigerator, used a key from key ring which hung around her neck, unlocked the box, and removed one (1) needle. Client D attached the needle to the end of one (1) Byetta (Insulin medication to treat Diabetes Mellitus) 5mcg (microgram),</p>	W 0382	<p>Client D is independent in administering her insulin medication. A retraining will be completed with Client D regarding keeping her insulin medication secured when not in use. Training will include not leaving insulin box unlocked where other clients can access medication or needles if she leaves the area to administer insulin. Staff will receive retraining to include redirecting Client D to secure/lock the insulin box when not in use.</p> <p>All staff will receive retraining on ensuring that the medication cabinet and all other medications are locked during medication administration when exiting the medication area for any reason.</p> <p>Home Manager and/or QIDP will complete medication administration observations at least twice per week for four weeks to ensure that all staff are locking the medication cabinet during medication administration when staff are out of the area for any reason and that Client D is</p>	07/17/2015	

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	<p>left the open and unsecured black box sitting on the kitchen counter, and went into the bathroom to administer her insulin medication independently. Inside the unsecured and open medication black storage box was two (2) additional Byetta 5mcg insulin pens and nine disposable needles. From 7:00am until 7:10am, GHS #8 stayed in the medication area in the front foyer of the group home and could not see the location of the unsecured medication in the kitchen. At 7:10am, client D returned to the unsecured and open medication box, replaced her Byetta insulin pen into the box, and locked the box. Client D placed the secured box back into the refrigerator, walked to the medication area in the front foyer area, disposed of the used needle into a sharps container inside the medication cabinet, and indicated to GHS #8 she had taken her insulin medication. At 7:18am, GHS #8 indicated client medication should be secured when not being administered.</p> <p>On 6/29/15 at 5:15pm, an interview with the House Manager (HM) was conducted. The HM indicated medications should be kept locked and secured when not being administered. The HM indicated indicated the facility followed "Living in the Community" Core A/Core B procedures for medication administration.</p>		<p>keeping her insulin medication box secured if she leaves the area to administer her insulin.</p> <p>Ongoing, the Home Manager and/or QIDP will complete medication administration observations at least once per week to ensure that all staff are locking the medication cabinet during medication administration when staff are out of the area for any reason and that Client D is keeping her insulin medication box secured if she leaves the area to administer her insulin.</p> <p>Responsible Party: Home Manager, QIDP</p>	

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	<p>On 6/29/15 at 6:00pm, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medications should be kept secured when not being administered.</p> <p>9-3-6(a)</p>				