

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  08/28/2015
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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 PCR (Post Certification Revisit) to the investigation of complaint #IN00176248 completed on 7/1/2015 which resulted in an Immediate Jeopardy.</p> <p>Complaint #IN00176248: Not Corrected.</p> <p>This visit was in conjunction with the investigation of complaint #IN00179045.</p> <p>This visit was in conjunction with a PCR (Post Certification Revisit) to the investigation of complaint #IN00171443 completed on 6/4/2015.</p> <p>Dates of Survey: 8/24, 8/25, 8/26, 8/27, and 8/28/2015.</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. Quality Review of this report completed by #15068 on 9/4/15.</p>	W 0000		
W 0104  Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general</p>			

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>policy, budget, and operating direction over the facility.</p> <p>Based on interview and record review for 3 of 3 sampled clients (B, C, and H), 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 behaviors, to ensure staffing levels were sufficient in the home, 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 W149. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure implementation of the agency's policy and procedure to prohibit abuse, neglect, mistreatment, and/or exploitation and to complete thorough investigations for 2 of 2 allegations of abuse reviewed for client B and C's verbally and physically aggressive behaviors toward client H. The governing body failed to ensure the facility staff immediately reported to the facility's administrator and to BDDS (Bureau of Developmental Disabilities</p>	W 0104	<ol style="list-style-type: none"> <li>1. Please refer to W149</li> <li>2. Please refer to W153</li> <li>3. Please refer to W154</li> <li>4. Please refer to W157</li> </ol>	09/27/2015

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	<p>Services) when staff neglected to ensure sufficient staff were available on duty at the group home to supervise and to implement client B, C, and H's ISPs (Individual Support Plan), BSPs (Behavior Support Plan), and Risk Plans. The governing body failed to ensure the facility implemented effective safeguards and corrective measures regarding client B and C's continued aggressive behaviors.</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 staff immediately reported to the facility's administrator and to 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 when staff failed to ensure sufficient staff were available on duty at the group home to supervise clients and failed to report clients B and C's aggressive behaviors targeting client H for 2 of 2 allegations of abuse reviewed for 3 of 3 sampled clients (clients B, C, and H).</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 allegations of</p>			

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	<p>abuse, neglect, and/or mistreatment regarding client B and C's verbally and physically aggressive behaviors toward client H and insufficient staff on duty at the group home for 2 of 2 investigations reviewed for 3 of 3 sampled clients (clients B, C, and H).</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 ensure staff were available to supervise clients and to implement corrective measures regarding client B and C's continued aggressive behaviors toward client H for 2 of 2 BDDS (Bureau of Developmental Disabilities Services) reports reviewed and 2 of 2 investigations of allegations of abuse, neglect, and/or mistreatment for 3 of 3 sampled clients (clients B, C, and H).</p> <p>This deficiency was cited on 7/1/2015. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN00176248.</p> <p>9-3-1(a)</p>			

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W 0149  Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, for 3 of 3 sampled clients (clients B, C, and H), 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 2 of 2 allegations of abuse investigations reviewed for client B and C's verbally and physically aggressive behaviors toward client H.</p> <p>The facility neglected to immediately report to the facility's administrator and to BDDS (Bureau of Developmental Disabilities Services) when staff neglected to ensure sufficient staff were available on duty at the group home to supervise and to implement client B, C, and H's ISPs (Individual Support Plan), BSPs (Behavior Support Plan), and Risk Plans.</p> <p>The facility neglected to implement effective safeguards and corrective measures regarding client B and C's continued aggressive behaviors.</p> <p>Findings include:</p>			W 0149	<p>1. 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 and what corrective measures are recommended to ensure all consumers safety. 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</p>		09/27/2015

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	<p>1. On 8/24/15 at 12:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed from 7/1/15 through 8/24/15. The review indicated the following for clients B and H:</p> <p>-A 7/12/15 BDDS report for an incident on 7/12/15 at 10:00am indicated "On Sunday, 7/12/15 at 10:00am, the Program Director was notified by the On Call Home Manager that [client B] was physically aggressive with her roommate [client H] in the Group Home over a bracelet that [client B] alleged had been stolen from her. Staff report they had to use Physical Intervention to get [client B] off of her roommate whom was having trouble defending herself while in her wheelchair." The report indicated clients B and H had no injuries noted.</p> <p>-The 7/28/15 completed "Summary of Internal Investigation Report" for the 7/12/15 incident indicated "...[Client B] has a history of physical aggression towards different housemates in her Group Home. The client has a history of false allegations that have been previously investigated." The "Factual Findings" indicated GHS (Group Home Staff) #4 "indicated [client H] came into the kitchen to get her breakfast and</p>		<p>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 staff that reported to work late received corrective action for reporting late to her shift. The staff that failed to report being alone with seven clients when and incident occurred between two consumers that required physical restraint being used by one client receive corrective action for failing to report the other staff coming in late and therefore not being able to fulfill the staffing ratios that had been put in place for client safety.</p> <p>All direct care staff received retraining on ensuring that if a situation arose when the designated staffing ratios could not be met, it was required to report to the on call supervisor so that immediate plans could be made to ensure additional staffing was available to maintain the ratios.</p> <p>Management observations will be</p>	

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	<p>[client B] started an argument with [client H]. [Client B] claimed [client H] had on her necklace (sic)...[Client H] said that the necklace (sic) belonged to her and refused to give it [to client B], so they started arguing. [Client B] called her mom and her mom kept calling the house telling [GHS #4] to get [client H] to give the necklace (sic) back to [client B]...[GHS #4] stated they were going to take the bracelet (sic) to calm down confusion about whose bracelet (sic) it was when [client B] grabbed [client H] and started twisting [client H's] arm vigorously. [Client H] started hollering. [GHS #4] did PIA (Physical Intervention Alternative) until [client B] calmed down. [Client B] continued to be verbally aggressive. [GHS #4] contacted the On Call Home Manager who came over and did a report."</p> <p>-The 7/28/15 investigation indicated "Upon interviewing the On Call House Manager [Name of person] stated that she arrived to the shift at 9:46am because she was informed via the telephone by [GHS #4] that there had just been an incident of PIA. [The On Call House Manager] stated that upon arrival she found that [GHS #4] was alone on shift...the 2nd (second) person working had not shown up and she wasn't sure who it was because a lot of different people were</p>		<p>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. 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.</p> <p>2. 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</p>		

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	<p>picking up shifts." The investigation indicated the second staff arrived at 10:31am and client B was "still visibly upset."</p> <p>-The 7/28/15 investigation indicated "Upon interviewing [client H], she stated [client B] let her [client H] borrow her white and blue bracelet with a matching necklace. [Client H] said that [client B] made it at the [name of day program] and she thought [client B] had given it to her. [Client H] stated that [client B] then started to rip it off her [client H's] arm and that's when [GHS #4] physically intervened. When [GHS #4] tried to come behind [client B], and get her arm and then they both fell back onto the floor. [Client H] said [client B] was screaming at the top of her lungs that [GHS #4] was beating on her, but that is not what happened. [Client H] said [GHS #4] was just trying to keep [client H] safe." Client H then requested a change of bedrooms since clients B and H had shared a room before the incident.</p> <p>-The 7/28/15 investigation indicated "When [client B] was interviewed, she stated that she was choked by [GHS #4] and that [GHS #4] jumped on [client B's] back...When asked if she grabbed the bracelet off of [client H's] arm, [client B] said yes. When asked if she was</p>		<p>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 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>	

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	<p>grabbing it roughly, trying to get it off, [client B] said yes, but she didn't mean to. [Client B] said she just wanted her bracelet back and [client H] would not give it to her...(client B said) she knows [client H] is smaller than her and she would not hurt that girl...When asked why [client B] gave it to [client H] in the first place, going against the rules of sharing items with each other, [client B] stated because [client H] said she liked it but that she did not mean for [client H] to keep it forever."</p> <p>-The 7/28/15 investigation was not thorough in that: The investigation did not indicate the specific questions asked during each interview; the investigation did not include a review of the staffing ratios for the group home; the investigation did not include the specific time frame when GHS #4 was left alone with seven clients; the investigation did not indicate a completed interview with the overnight staff as to why the staff person left the group home and left the clients without sufficient staff members on duty to supervise and to implement each client's ISP, BSP, and Risk Plans; and the investigation did not indicate recommendations as a result of the investigation.</p> <p>On 8/24/15 at 1:20pm, an interview was</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: QIDP, Regional Quality Assurance Specialist, Area Director</p>	

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	<p>conducted with the Area Director (AD). The AD indicated the facility followed the BDDS reporting guidelines for abuse, neglect, and/or mistreatment. The AD stated the facility "should have at least two (2)" staff members "on duty whenever the clients" in the group home were awake. The AD indicated clients B and C had identified behaviors of physical aggression, verbal aggression, and AWOL (Absent Without Leave) and stated "There should always be at least two staff present." The AD indicated on 7/12/15 clients B, C, D, E, F, G, and H were awake and in the kitchen when the incident occurred between clients B and H with one staff (GHS #4). The AD stated "No, the staff did not report to the On Call House Manager on 7/12/15 when the overnight staff person had left the group home and the second day shift staff was not on duty at the group home." The AD indicated GHS #3 received corrective action for reporting late to her shift and GHS #4 received corrective action for failing to immediately report being alone with seven clients. The AD indicated GHS #4 contacted the On Call House Manager to report client to client physical aggression between clients B and H which resulted in physical restraints being used on client B. The AD indicated the staff neglected to report immediately to the administrator that</p>			

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	<p>sufficient staff were not present in the group home after 8am until 10:31am when GHS #3 arrived to the group home as the second staff person. The AD indicated the investigation was not thorough in that no narrative witness statements were available for review, no documented questions asked during the interviews were available for review, no staffing ratios for the group home were reviewed; no specific time frame of when GHS #4 was left alone with clients B, C, D, E, F, G, and H, and no interview with the overnight staff was conducted. The AD stated one staff on duty in the group home "cannot supervise" and/or implement each client's ISP, BSP, and Risk Plans and the investigation did not indicate recommendations as a result of the investigation.</p> <p>2. On 8/24/15 at 12:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed from 7/1/15 through 8/24/15. The review indicated the following for clients C and H:</p> <p>-An 8/22/15 BDDS report for an incident on 8/21/15 at 4:40pm indicated "At 5:03pm, the Program Director was notified by the staff that [client C] had done the following: refused her medication, eloped and returned to the</p>			

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	<p>home twice, threw a plastic object about the length of a ruler and width of 4 x 6 (four inches by six inches) picture frame at the staff, hitting [the staff] in the forehead, had bitten the staff on the staff's hand breaking the skin, punched the staff in the head multiple times with closed fist and breaking the staff's glasses. The staff member stated that 9-1-1 was called and Police stated they were on their way to the home. Upon Police arrival to the home, the staff stated that the client urinated on herself and threatened suicide. A Police Officer told the client they were transporting them to [Name of Hospital] Emergency Room at which time the client refused. After being asked multiple times to get into the Police vehicle and the client refusing, the staff present were told by the Police that the Police could not force the client to go to the Emergency Room and the Police left the site. At 5:30pm, the Program Director arrived to the site and transported the client to [Name of Hospital] Stress Center due to further threats of self harm. While on the way to the Stress Center, the client was asked what happened and she stated that she hit a staff member because they kept telling her what to do. [Client C] also alleged that the staff member then hit her back." The report indicated client C refused to "stay at the Stress Center overnight to</p>			

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	<p>calm back down" and client C "wanted to go home." The report indicated client C "was calm after visiting the Stress Center for two hours" and released to return to the group home. The report indicated client C had no further incidents and was calm at the group home.</p> <p>On 8/28/15 at 10:30am, a review of the 8/21/15 investigation was conducted and indicated the following: -An 8/21/15 investigation indicated the two staff involved in the allegation were suspended pending the investigation. The investigation did not include narrative witness statements and responses were paraphrased by the PD (Program Director) for interviews. The investigation indicated "Background of client...[Client C] can advocate for herself but she also has False Reporting as a Targeted Behavior on her BSP... [Client H] can report what occurred in an event. She is generally not considered a reliable reporter when she has been the cause of an incident with a negative result."</p> <p>-The 8/21/15 investigation indicated an "Interview with [client C]...Said on 8/21/15 she was mad at [client H] while attended (sic) [Day Services] concerning a boy. Said then when she [client C] got home from [name of Day Services] the</p>			

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	<p>staff started telling her what to do...Said she got mad because [name of staff] wanted her to take her medicine when she got home but she didn't want to take it. Said staff told her to go to her room but she didn't want to go to her room. Said she did not know why staff asked her to go to her room...[Client C] hit [staff] in the eye with an air freshener...then punched [staff] in the face breaking her (the staff's) glasses...staff responded by trying to put [the staff's] hands on [client C] like when [clients A and B] get PIA...[client C] said this made her mad and she fought back by continuing to punch [staff], said [staff] hit her back...[a different staff] got between them, [staff] tried to put her arm around her so [client C] bit her on the arm...[Client C] said she went to her room...then went outside and sat on the chair on the porch...[GHS #10] informed [client C] they had called the police...I pee'd on the chair and I didn't want to go to the Emergency Room...[Client C] said when the Police come (sic), I just sit (sic), and then they go away...."</p> <p>-The 8/21/15 investigation indicated an "Interview with [GHS #11]." GHS #11 indicated when she arrived at the Day Services to pick up clients, client C was "upset with [client H]...over a boy," and prompted client C to "stop yelling and</p>			

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	<p>calling [client H] names...[Client C] got on the van and then started to call both [staff] [profane names]." GHS #11 indicated client C continued to be verbally aggressive on the van on the way home from Day Services, upon arrival home "cursed very loudly...targeted [client H], telling [client H] that she was going to kill her and then she (client C) was going to kill herself...trying to cut herself with the back and forth action across her wrist with the headband...ran out of the house...threatened to kill her housemate which [client C] had never done before...threatening to kill herself...returned to the group home calling staff (profane names)...staff offered 4pm medications...[client C] refused, turned to [client D] and told [client D] she was fat" and client C became physically aggressive toward the staff.</p> <p>-The 8/21/15 investigation indicated an "Interview with [Client D]...said [client C] was screaming and yelling on the van...when they got home [client C] called her fat...said [client C] said she was going to kill [client H] and that she just kept calling me fat...said when [client C] began to throw things she [client D] went to her room...."</p> <p>-The 8/21/15 investigation indicated an</p>			

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	<p>"Interview with [Client H]...said [client C] was upset with her because she was talking to a guy friend of [client C's] right before transport. Said [client C] called all kinds [her] of things like b---- and wh---...Said when they got home [client C] said she was going to kill her...Said she [client H] stayed near staff in the living room as a result. Said [client C] was just out of control. [Client H] said she was scared...[client C] called [client D] fat...."</p> <p>The 8/21/15 investigation indicated "Evidence does not support the allegation of abuse."</p> <p>The 8/21/15 investigation was not thorough in that: The investigation did not indicate the specific questions asked during each interview and the investigation did not indicate corrective action recommendations as a result of the investigation. The investigation did not include investigating client C's threats of physical harm toward client H, reporting the threats of physical harm to BDDS and the Administrator, and corrective measures to ensure client H's safety.</p> <p>On 8/28/15 at 1:45pm, a review of client C's 8/26/15 "IDT (Interdisciplinary Team) Note" was reviewed. The 8/26/15 IDT indicated client C's BSP was reviewed regarding the 8/21/15 incident and "Targeted behaviors already address</p>			

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	<p>what took place. Those behaviors are as follows: Self Injurious behavior, Aggressive Outbursts, Verbal Aggression, False Reporting, Vacating, Physical Aggression. Plan reviewed and determined to be sufficient to address any future behaviors...."</p> <p>On 8/24/15 at 4:00pm, an interview was conducted with the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional). The PD/QIDP stated clients B and C "target" client H. The PD/QIDP indicated client H was smaller in her body build, sat in a wheelchair, and clients B and C were larger body builds, taller, and stronger than client H. The PD/QIDP stated the investigation was "in process" on 8/24/15 and had not been completed. The PD/QIDP indicated no corrective measures had been added to ensure client H's safety because no changes in client C's plans had been recommended.</p> <p>On 8/28/15 at 3:15pm, an interview with the AD was conducted. The AD indicated the 8/21/15 investigation was not thorough in that the investigation did not indicate the specific questions asked during each interview and the investigation did not indicate corrective action recommendations as a result of the investigation. The investigation did not</p>			

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	<p>include investigating client C's threats of physical harm toward client H, reporting the threats of physical harm to BDDS and the Administrator, and corrective measures to ensure client H's safety.</p> <p>On 8/24/15 at 2:45pm, client B's record was reviewed. Client B's 7/10/15 ISP (Individual Support Plan) and 7/10/15 BSP (Behavior Support Plan) included targeted behaviors of elopement behaviors, Physical Aggression, Verbal Aggression, Inappropriate Social Behavior, Excessive Consumption, and Resistance to Instruction.</p> <p>Client C's record was reviewed on 8/24/15 at 2:20 PM and on 8/25/15 at 3:45 PM. Client C's 7/10/15 ISP and 7/10/15 BSP indicated the targeted behaviors of Self Injurious Behavior, Aggressive Outburst, Verbal Aggression, False Reporting, Vacating, and Physical Aggression.</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]</p>			

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	<p>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 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</p>			

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	<p>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 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</p>			

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	<p>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.</p> <p>(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 7/2015 "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>Client H's record was reviewed on 8/24/15 at 3:00pm and on 8/25/15 at 3:15pm. Client H's 10/31/14 ISP indicated the client's diagnoses included, but were not limited to the diagnosis of: Mild Mental Retardation and Spinal Bifid. Client H's record indicated she used a wheel chair for mobility. Client H's 7/10/15 BSP included the targeted</p>			

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	<p>behavior of False Reporting.</p> <p>The facility's policy and procedures were reviewed on 8/24/15 at 12:45pm. The 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 and development of further recommendations as needed within 5 days of the incident."</p> <p>This deficiency was cited on 7/1/2015. The facility failed to implement a systemic plan of correction to prevent</p>			

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W 0153 Bldg. 00	<p>recurrence.</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 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 record review and interview, for 2 of 2 allegations of abuse reviewed for 3 of 3 sampled clients (clients B, C, and H), the facility failed to immediately report to the facility's administrator and to 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 when staff failed to ensure sufficient staff were available on duty at the group home to supervise clients and failed to report clients B and C's aggressive behaviors targeting client H.</p> <p>Findings include:</p> <p>1. On 8/24/15 at 12:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and</p>	W 0153	<p>QIDP will receive retraining to include ensuring that when incident reports are submitted to the Bureau of Developmental Disability Services that they are thorough and include all pertinent information regarding the incident in regard to all consumers' health and safety. Training will include ensuring that if multiple BDDS reportable situations are reported within the same incident that all reportable situations are included in one BDDS report or multiple reports for the separate incidents are 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</p>	09/27/2015

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	<p>investigations were reviewed from 7/1/15 through 8/24/15. The review indicated the following for clients B and H:</p> <p>-A 7/12/15 BDDS report for an incident on 7/12/15 at 10:00am indicated "On Sunday, 7/12/15 at 10:00am, the Program Director was notified by the On Call Home Manager that [client B] was physically aggressive with her roommate [client H] in the Group Home over a bracelet that [client B] alleged had been stolen from her. Staff report they had to use Physical Intervention to get [client B] off of her roommate whom was having trouble defending herself while in her wheelchair."</p> <p>-The 7/28/15 completed "Summary of Internal Investigation Report" for the 7/12/15 incident indicated "...[Client B] has a history of physical aggression towards different housemates in her Group Home." The "Factual Findings" indicated GHS (Group Home Staff) #4 "indicated [client H] came into the kitchen to get her breakfast and [client B] started an argument with [client H]. [Client B] claimed [client H] had on her necklace (sic)...[Client H] said that the necklace belonged to her and refused to give it [to client B], so they started arguing...[GHS #4] stated they were going to take the bracelet (sic) to calm</p>		<p>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>Ongoing, the Area Director will review all submitted BDDS reports and investigations and ensure that all BDDS reportable incidents are included in one BDDS report or multiple BDDS reports are filed as needed.</p> <p>Responsible Party: Program Coordinator, QIDP, Area Director</p>	

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	<p>down confusion about whose bracelet (sic) it was when [client B] grabbed [client H] and started twisting [client H's] arm vigorously. [Client H] started hollering. [GHS #4] did PIA (Physical Intervention Alternative) until [client B] calmed down. [Client B] continued to be verbally aggressive. [GHS #4] contacted the On Call Home Manager who came over and did a report."</p> <p>-The 7/28/15 investigation indicated "Upon interviewing the On Call House Manager [Name of person] stated that she arrived to the shift at 9:46am because she was informed via the telephone by [GHS #4] that there had just been an incident of PIA. [The On Call House Manager] stated that upon arrival she found that [GHS #4] was alone on shift...the 2nd (second) person working had not shown up and she wasn't sure who it was because a lot of different people were picking up shifts." The investigation indicated the second staff arrived at 10:31am and client B was "still visibly upset."</p> <p>-The 7/28/15 investigation indicated "Upon interviewing [client H], she stated [client B] let her [client H] borrow her white and blue bracelet with a matching necklace. [Client H] said that [client B] made it at the [name of day program] and</p>			

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	<p>she thought [client B] had given it to her. [Client H] stated that [client B] then started to rip it off her [client H's] arm and that's when [GHS #4] physically intervened. When [GHS #4] tried to come behind [client B], and get her arm and then they both fell back onto the floor..[Client H] said [GHS #4] was just trying to keep [client H] safe." Client H then requested a change of bedrooms since clients B and H had shared a room before the incident.</p> <p>On 8/24/15 at 1:20pm, an interview was conducted with the Area Director (AD). The AD stated the facility "should have at least two (2)" staff members "on duty whenever the clients" in the group home were awake. The AD indicated clients B and C had identified behaviors of physical aggression, verbal aggression, and AWOL (Absent Without Leave) and stated "There should always be at least two staff present." The AD indicated on 7/12/15 clients B, C, D, E, F, G, and H were awake and in the kitchen when the incident occurred between clients B and H with one staff (GHS #4). The AD stated "No, the staff did not report to the On Call House Manager on 7/12/15 when the overnight staff person had left the group home and the second day shift staff was not on duty at the group home. The AD indicated GHS #4 received corrective</p>			

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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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	<p>action for failing to immediately report being alone with seven clients. The AD indicated GHS #4 contacted the On Call House Manager to report client to client physical aggression between clients B and H which resulted in physical restraints being used on client B. The AD indicated the staff failed to report immediately to the administrator that sufficient staff were not present in the group home after 8am until 10:31am when GHS #3 arrived to the group home as the second staff person. The AD stated one staff on duty in the group home "cannot supervise" and/or implement each client's ISP, BSP, and Risk Plans.</p> <p>2. On 8/24/15 at 12:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed from 7/1/15 through 8/24/15. The review indicated the following for clients C and H:</p> <p>-An 8/22/15 BDDS report for an incident on 8/21/15 at 4:40pm indicated "At 5:03pm, the Program Director was notified by the staff that [client C] had done the following: refused her medication, eloped and returned to the home twice, threw a plastic object about the length of a ruler and width of 4 x 6 (four inches by six inches) picture frame</p>			

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	<p>at the staff, hitting [the staff] in the forehead, had bitten the staff on the staff's hand breaking the skin, punched the staff in the head multiple times with closed fist and breaking the staff's glasses. The staff member stated that 9-1-1 was called and Police stated they were on their way to the home. Upon Police arrival to the home, the staff stated that the client urinated on herself and threatened suicide. A Police Officer told the client they were transporting them to [Name of Hospital] Emergency Room at which time the client refused. After being asked multiple times to get into the Police vehicle and the client refusing, the staff present were told by the Police that the Police could not force the client to go to the Emergency Room and the Police left the site. At 5:30pm, the Program Director arrived to the site and transported the client to [Name of Hospital] Stress Center due to further threats of self harm. While on the way to the Stress Center, the client was asked what happened and she stated that she hit a staff member because they kept telling her what to do. [Client C] also alleged that the staff member then hit her back." The report indicated client C refused to "stay at the Stress Center overnight to calm back down" and client C "wanted to go home." The report indicated client C "was calm after visiting the Stress Center</p>			

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	<p>for two hours" and released to return to the group home. The report indicated client C had no further incidents and was calm at the group home.</p> <p>On 8/28/15 at 10:30am, a review of the 8/21/15 investigation was conducted and indicated the following: -The 8/21/15 investigation indicated an "Interview with [client C]...Said on 8/21/15 she was mad at [client H] while attended [Day Services] concerning a boy. Said then when she [client C] got home from [name of Day Services] the staff started telling her what to do...."</p> <p>-The 8/21/15 investigation indicated an "Interview with [GHS #11]." GHS #11 indicated when she arrived at the Day Services to pick up clients, client C was "upset with [client H]...over a boy," and prompted client C to "stop yelling and calling [client H] names...[Client C] got on the van and then started to call both [staff] [profane names]." GHS #11 indicated client C continued to be verbally aggressive on the van on the way home from Day Services, upon arrival home "cursed very loudly...targeted [client H], telling [client H] that she was going to kill her and then she (client C) was going to kill herself..trying to cut herself with the back and forth action across her wrist with the headband...ran</p>			

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	<p>out of the house...threatened to kill her housemate which [client C] had never done before...threatening to kill herself...returned to the group home calling staff (profane names)...staff offered 4pm medications...[client C] refused, turned to [client D] and told [client D] she was fat" and client C became physically aggressive toward the staff.</p> <p>-The 8/21/15 investigation indicated an "Interview with [Client D]...said [client C] was screaming and yelling on the van...when they got home [client C] called her fat...said [client C] said she was going to kill [client H] and that she just kept calling me fat...said when [client C] began to throw things she [client D] went to her room...."</p> <p>-The 8/21/15 investigation indicated an "Interview with [Client H]...said [client C] was upset with her because she was talking to a guy friend of [client C's] right before transport. Said [client C] called all kinds of things like b--- and wh--...Said when they got home [client C] said she was going to kill her...Said she [client H] stayed near staff in the living room as a result. Said [client C] was just out of control. [Client H] said she was scared...[client C] called [client D] fat...."</p>			

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	<p>The 8/21/15 investigation indicated "Evidence does not support the allegation of abuse."</p> <p>The 8/21/15 investigation did not include investigating client C's threats of physical harm toward client H and reporting the threats of physical harm to BDDS and the Administrator.</p> <p>On 8/24/15 at 4:00pm, an interview was conducted with the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional). The PD/QIDP stated clients B and C "target" client H.</p> <p>On 8/28/15 at 3:15pm, an interview with the AD was conducted. The AD indicated the 8/21/15 incident of client C's physical aggression toward the staff was reported to BDDS and the report did not include the allegation of client C's physical harm threats targeting client H.</p> <p>This deficiency was cited on 7/1/2015. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN00176248.</p> <p>9-3-2(a)</p>			

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W 0154  Bldg. 00	<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 2 of 2 investigations for allegations of abuse, neglect, and/or mistreatment reviewed for 3 of 3 sampled clients (clients B, C, and H), the facility failed to complete thorough investigations regarding client B and C's verbally and physically aggressive behaviors toward client H and insufficient staff on duty at the group home.</p> <p>Findings include:</p> <p>1. On 8/24/15 at 12:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed from 7/1/15 through 8/24/15. The review indicated the following for clients B and H:</p> <p>-A 7/12/15 BDDS report for an incident on 7/12/15 at 10:00am indicated "On Sunday, 7/12/15 at 10:00am, the Program Director was notified by the On Call Home Manager that [client B] was physically aggressive with her roommate [client H] in the Group Home over a bracelet that [client B] alleged had been stolen from her. Staff report they had to use Physical Intervention to get [client B]</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 and what corrective measures are recommended to ensure all consumers safety. 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</p>	09/27/2015

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	<p>off of her roommate whom was having trouble defending herself while in her wheelchair." The report indicated clients B and H had no injuries noted.</p> <p>-The 7/28/15 completed "Summary of Internal Investigation Report" for the 7/12/15 incident indicated "...[Client B] has a history of physical aggression towards different housemates in her Group Home." The "Factual Findings" indicated GHS (Group Home Staff) #4 "indicated [client H] came into the kitchen to get her breakfast and [client B] started an argument with [client H]. [Client B] claimed [client H] had on her necklace (sic)...[Client H] said that the necklace (sic) belonged to her and refused to give it [to client B], so they started arguing...[GHS #4] stated they were going to take the bracelet (sic) to calm down confusion about whose bracelet (sic) it was when [client B] grabbed [client H] and started twisting [client H's] arm vigorously. [Client H] started hollering. [GHS #4] did PIA (Physical Intervention Alternative) until [client B] calmed down. [Client B] continued to be verbally aggressive. [GHS #4] contacted the On Call Home Manager who came over and did a report."</p> <p>-The 7/28/15 investigation indicated</p>		<p>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>Responsible Party: QIDP, Regional Quality Assurance Specialist, Area Director</p>	

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	<p>"Upon interviewing the On Call House Manager [Name of person] stated that she arrived to the shift at 9:46am because she was informed via the telephone by [GHS #4] that there had just been an incident of PIA. [The On Call House Manager] stated that upon arrival she found that [GHS #4] was alone on shift...the 2nd (second) person working had not shown up and she wasn't sure who it was because a lot of different people were picking up shifts." The investigation indicated the second staff arrived at 10:31am and client B was "still visibly upset."</p> <p>-The 7/28/15 investigation indicated "Upon interviewing [client H], she stated [client B] let her [client H] borrow her white and blue bracelet with a matching necklace. [Client H] said that [client B] made it at the [name of day program] and she thought [client B] had given it to her. [Client H] stated that [client B] then started to rip it off her [client H's] arm and that's when [GHS #4] physically intervened. When [GHS #4] tried to come behind [client B], and get her arm and then they both fell back onto the floor. [Client H] said [client B] was screaming at the top of her lungs that [GHS #4] was beating on her, but that is not what happened. [Client H] said [GHS #4] was just trying to keep [client</p>			
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	<p>H] safe." Client H then requested a change of bedrooms since clients B and H had shared a room before the incident.</p> <p>-The 7/28/15 investigation indicated "When [client B] was interviewed, she stated that she was choked by [GHS #4] and that [GHS #4] jumped on [client B's] back...When asked if she grabbed the bracelet off of [client H's] arm, [client B] said yes. When asked if she was grabbing it roughly, trying to get it off, [client B] said yes, but she didn't mean to. [Client B] said she just wanted her bracelet back and [client H] would not give it to her...(client B said) she knows [client H] is smaller than her and she would not hurt that girl...When asked why [client B] gave it to [client H] in the first place, going against the rules of sharing items with each other, [client B] stated because [client H] said she liked it but that she did not mean for [client H] to keep it forever."</p> <p>-The 7/28/15 investigation was not thorough in that: The investigation did not indicate the specific questions asked during each interview; the investigation did not include a review of the staffing ratios for the group home; the investigation did not include the specific time frame when GHS #4 was left alone with seven clients; the investigation did</p>			

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	<p>not indicate a completed interview with the overnight staff as to why the staff person left the group home and left the clients without sufficient staff members on duty to supervise and to implement each client's ISP, BSP, and Risk Plans; and the investigation did not indicate recommendations as a result of the investigation.</p> <p>On 8/24/15 at 1:20pm, an interview was conducted with the Area Director (AD). The AD stated the facility "should have at least two (2)" staff members "on duty whenever the clients" in the group home were awake. The AD indicated clients B and C had identified behaviors of physical aggression, verbal aggression, and AWOL (Absent Without Leave) and stated "There should always be at least two staff present." The AD indicated on 7/12/15 clients B, C, D, E, F, G, and H were awake and in the kitchen when the incident occurred between clients B and H with one staff (GHS #4). The AD indicated that sufficient staff were not present in the group home after 8am until 10:31am when GHS #3 arrived to the group home as the second staff person. The AD indicated the investigation was not thorough in that no narrative witness statements were available for review, no documented questions asked during the interviews were available for review, no</p>			

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	<p>staffing ratios for the group home were reviewed; no specific time frame of when GHS #4 was left alone with clients B, C, D, E, F, G, and H, and no interview with the overnight staff was conducted. The AD stated one staff on duty in the group home "cannot supervise" and/or implement each client's ISP, BSP, and Risk Plans and the investigation did not indicate recommendations as a result of the investigation.</p> <p>2. On 8/24/15 at 12:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed from 7/1/15 through 8/24/15. The review indicated the following for clients C and H:</p> <p>-An 8/22/15 BDDS report for an incident on 8/21/15 at 4:40pm indicated "At 5:03pm, the Program Director was notified by the staff that [client C] had done the following: refused her medication, eloped and returned to the home twice, threw a plastic object about the length of a ruler and width of 4 x 6 (four inches by six inches) picture frame at the staff, hitting [the staff] in the forehead, had bitten the staff on the staff's hand breaking the skin, punched the staff in the head multiple times with closed fist and breaking the staff's glasses. The staff member stated that 9-1-1 was called and</p>			

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	<p>Police stated they were on their way to the home. Upon Police arrival to the home, the staff stated that the client urinated on herself and threatened suicide. A Police Officer told the client they were transporting them to [Name of Hospital] Emergency Room at which time the client refused. After being asked multiple times to get into the Police vehicle and the client refusing, the staff present were told by the Police that the Police could not force the client to go to the Emergency Room and the Police left the site. At 5:30pm, the Program Director arrived to the site and transported the client to [Name of Hospital] Stress Center due to further threats of self harm. While on the way to the Stress Center, the client was asked what happened and she stated that she hit a staff member because they kept telling her what to do. [Client C] also alleged that the staff member then hit her back." The report indicated client C refused to "stay at the Stress Center overnight to calm back down" and client C "wanted to go home." The report indicated client C "was calm after visiting the Stress Center for two hours" and released to return to the group home. The report indicated client C had no further incidents and was calm at the group home.</p> <p>On 8/28/15 at 10:30am, a review of the</p>			

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	<p>8/21/15 investigation was conducted and indicated the following:</p> <p>-An 8/21/15 investigation indicated the two staff involved in the allegation were suspended pending the investigation. The investigation did not include narrative witness statements and responses were paraphrased by the PD (Program Director) for interviews. The investigation indicated "Background of client...[Client C] can advocate for herself but she also has False Reporting as a Targeted Behavior on her BSP... [Client H] can report what occurred in an event. She is generally not considered a reliable reporter when she has been the cause of an incident with a negative result."</p> <p>-The 8/21/15 investigation indicated an "Interview with [client C]...Said on 8/21/15 she was mad at [client H] while attended (sic) [Day Services] concerning a boy. Said then when she [client C] got home from [name of Day Services] the staff started telling her what to do...Said she got mad because [name of staff] wanted her to take her medicine when she got home but she didn't want to take it. Said staff told her to go to her room but she didn't want to go to her room. Said she did not know why staff asked her to go to her room...[Client C] hit [staff] in the eye with an air</p>			

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	<p>freshener...then punched [staff] in the face breaking her (the staff's) glasses...staff responded by trying to put [the staff's] hands on [client C] like when [clients A and B] get PIA...[client C] said this made her mad and she fought back by continuing to punch [staff], said [staff] hit her back...[a different staff] got between them, [staff] tried to put her arm around her so [client C] bit her on the arm...[Client C] said she went to her room...then went outside and sat on the chair on the porch...[GHS #10] informed [client C] they had called the police...I pee'd on the chair and I didn't want to go to the Emergency Room...[Client C] said when the Police come (sic), I just sit (sic), and then they go away...."</p> <p>-The 8/21/15 investigation indicated an "Interview with [GHS #11]." GHS #11 indicated when she arrived at the Day Services to pick up clients, client C was "upset with [client H]...over a boy," and prompted client C to "stop yelling and calling [client H] names...[Client C] got on the van and then started to call both [staff] [profane names]." GHS #11 indicated client C continued to be verbally aggressive on the van on the way home from Day Services, upon arrival home "cursed very loudly...targeted [client H], telling [client H] that she was going to kill her and then she (client C)</p>			

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	<p>was going to kill herself...trying to cut herself with the back and forth action across her wrist with the headband...ran out of the house...threatened to kill her housemate which [client C] had never done before...threatening to kill herself...returned to the group home calling staff (profane names)...staff offered 4pm medications...[client C] refused, turned to [client D] and told [client D] she was fat" and client C became physically aggressive toward the staff.</p> <p>-The 8/21/15 investigation indicated an "Interview with [Client D]...said [client C] was screaming and yelling on the van...when they got home [client C] called her fat...said [client C] said she was going to kill [client H] and that she just kept calling me fat...said when [client C] began to throw things she [client D] went to her room...."</p> <p>-The 8/21/15 investigation indicated an "Interview with [Client H]...said [client C] was upset with her because she was talking to a guy friend of [client C's] right before transport. Said [client C] called [her] all kinds of things like b---- and wh--...Said when they got home [client C] said she was going to kill her...Said she [client H] stayed near staff in the living room as a result. Said [client C] was just</p>			

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	<p>out of control. [Client H] said she was scared...[client C] called [client D] fat...."</p> <p>The 8/21/15 investigation indicated "Evidence does not support the allegation of abuse."</p> <p>The 8/21/15 investigation was not thorough in that: The investigation did not indicate the specific questions asked during each interview. The investigation did not include investigating client C's threats of physical harm toward client H and reporting the threats of physical harm to BDDS and the Administrator.</p> <p>On 8/24/15 at 4:00pm, an interview was conducted with the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional). The PD/QIDP stated clients B and C "target" client H. The PD/QIDP indicated client H was smaller in her body build, sat in a wheelchair, and clients B and C were larger body builds, taller, and stronger than client H. The PD/QIDP stated the investigation was "in process" on 8/24/15 and had not been completed.</p> <p>On 8/28/15 at 3:15pm, an interview with the AD was conducted. The AD indicated the 8/21/15 investigation was not thorough in that the investigation did not indicate the specific questions asked during each interview. The investigation</p>			

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W 0157 Bldg. 00	<p>did not include investigating client C's threats of physical harm toward client H, reporting the threats of physical harm to BDDS and the Administrator, and corrective measures to ensure client H's safety.</p> <p>This deficiency was cited on 7/1/2015. The facility failed to implement a systemic plan of correction to prevent recurrence.</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 2 of 2 BDDS (Bureau of Developmental Disabilities Services) reports reviewed and 2 of 2 investigations of allegations of abuse, neglect, and/or mistreatment for 3 of 3 sampled clients (clients B, C, and H), the facility failed to implement sufficient safeguards to ensure staff were available to supervise clients and to implement corrective measures regarding client B and C's continued aggressive behaviors toward client H.</p>	W 0157	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	09/27/2015

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	<p>Findings include:</p> <p>1. On 8/24/15 at 12:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed from 7/1/15 through 8/24/15. The review indicated the following for clients B and H:</p> <p>-A 7/12/15 BDDS report for an incident on 7/12/15 at 10:00am indicated "On Sunday, 7/12/15 at 10:00am, the Program Director was notified by the On Call Home Manager that [client B] was physically aggressive with her roommate [client H] in the Group Home over a bracelet that [client B] alleged had been stolen from her. Staff report they had to use Physical Intervention to get [client B] off of her roommate whom was having trouble defending herself while in her wheelchair." No corrective action was available for review.</p> <p>-The 7/28/15 completed "Summary of Internal Investigation Report" for the 7/12/15 incident indicated "...[Client B] has a history of physical aggression towards different housemates in her Group Home. The client has a history of false allegations that have been previously investigated." The "Factual Findings" indicated GHS (Group Home Staff) #4 "indicated [client H] came into</p>		<p>will ensure that recommendations are made for what staff should do to prevent future incidents and what corrective measures are recommended to ensure all consumers safety. 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>Responsible Party: QIDP, Regional Quality Assurance Specialist, Area Director</p>		

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	<p>the kitchen to get her breakfast and [client B] started an argument with [client H]. [Client B] claimed [client H] had on her necklace (sic)...[Client H] said that the necklace (sic) belonged to her and refused to give it [to client B], so they started arguing...[GHS #4] stated they were going to take the bracelet (sic) to calm down confusion about whose bracelet (sic) it was when [client B] grabbed [client H] and started twisting [client H's] arm vigorously. [Client H] started hollering. [GHS #4] did PIA (Physical Intervention Alternative) until [client B] calmed down. [Client B] continued to be verbally aggressive."</p> <p>-The 7/28/15 investigation indicated "Upon interviewing the On Call House Manager [Name of person] stated that she arrived to the shift at 9:46am because she was informed via the telephone by [GHS #4] that there had just been an incident of PIA. [The On Call House Manager] stated that upon arrival she found that [GHS #4] was alone on shift...the 2nd (second) person working had not shown up and she wasn't sure who it was because a lot of different people were picking up shifts." The investigation indicated the second staff arrived at 10:31am and client B was "still visibly upset."</p>			

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	<p>-The 7/28/15 investigation indicated "Upon interviewing [client H], she stated [client B] let her [client H] borrow her white and blue bracelet with a matching necklace. [Client H] said that [client B] made it at the [name of day program] and she thought [client B] had given it to her. [Client H] stated that [client B] then started to rip it off her [client H's] arm and that's when [GHS #4] physically intervened. When [GHS #4] tried to come behind [client B], and get her arm and then they both fell back onto the floor. [Client H] said [client B] was screaming at the top of her lungs that [GHS #4] was beating on her, but that is not what happened. [Client H] said [GHS #4] was just trying to keep [client H] safe." Client H then requested a change of bedrooms since clients B and H had shared a room before the incident.</p> <p>-The 7/28/15 investigation indicated "When [client B] was interviewed, she stated that she was choked by [GHS #4] and that [GHS #4] jumped on [client B's] back...When asked if she grabbed the bracelet off of [client H's] arm, [client B] said yes. When asked if she was grabbing it roughly, trying to get it off, [client B] said yes, but she didn't mean to. [Client B] said she just wanted her bracelet back and [client H] would not give it to her...(client B said) she knows</p>			

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	<p>[client H] is smaller than her and she would not hurt that girl...When asked why [client B] gave it to [client H] in the first place, going against the rules of sharing items with each other, [client B] stated because [client H] said she liked it but that she did not mean for [client H] to keep it forever."</p> <p>-The 7/28/15 investigation did not include a review of the staffing ratios for the group home; the investigation did not include the specific time frame when GHS #4 was left alone with seven clients and did not indicate recommendations as a result of the investigation.</p> <p>On 8/24/15 at 1:20pm, an interview was conducted with the Area Director (AD). The AD stated the facility "should have at least two (2)" staff members "on duty whenever the clients" in the group home were awake. The AD indicated clients B and C had identified behaviors of physical aggression, verbal aggression, and AWOL (Absent Without Leave) and stated "There should always be at least two staff present." The AD indicated on 7/12/15 clients B, C, D, E, F, G, and H were awake and in the kitchen when the incident occurred between clients B and H with one staff (GHS #4). The AD stated "No, the staff did not report to the On Call House Manager on 7/12/15 when</p>			

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	<p>the overnight staff person had left the group home and the second day shift staff was not on duty at the group home." The AD indicated GHS #3 received corrective action for reporting late to her shift and GHS #4 received corrective action for failing to immediately report being alone with seven clients. The AD indicated the investigation did not include corrective measures. The AD stated one staff on duty in the group home "cannot supervise" and/or implement each client's ISP, BSP, and Risk Plans and the investigation did not indicate recommendations as a result of the investigation.</p> <p>2. On 8/24/15 at 12:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed from 7/1/15 through 8/24/15. The review indicated the following for clients C and H:</p> <p>-An 8/22/15 BDDS report for an incident on 8/21/15 at 4:40pm indicated "At 5:03pm, the Program Director was notified by the staff that [client C] had done the following: refused her medication, eloped and returned to the home twice, threw a plastic object about the length of a ruler and width of 4 x 6 (four inches by six inches) picture frame at the staff, hitting [the staff] in the</p>			

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	forehead, had bitten the staff on the staff's hand breaking the skin, punched the staff in the head multiple times with closed fist and breaking the staff's glasses. The staff member stated that 9-1-1 was called and Police stated they were on their way to the home. Upon Police arrival to the home, the staff stated that the client urinated on herself and threatened suicide. A Police Officer told the client they were transporting them to [Name of Hospital] Emergency Room at which time the client refused. After being asked multiple times to get into the Police vehicle and the client refusing, the staff present were told by the Police that the Police could not force the client to go to the Emergency Room and the Police left the site. At 5:30pm, the Program Director arrived to the site and transported the client to [Name of Hospital] Stress Center due to further threats of self harm. While on the way to the Stress Center, the client was asked what happened and she stated that she hit a staff member because they kept telling her what to do. [Client C] also alleged that the staff member then hit her back." The report indicated client C refused to "stay at the Stress Center overnight to calm back down" and client C "wanted to go home." The report indicated client C "was calm after visiting the Stress Center for two hours" and released to return to			

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	<p>the group home.</p> <p>On 8/28/15 at 10:30am, a review of the 8/21/15 investigation was conducted and indicated the following:</p> <p>-The 8/21/15 investigation indicated an "Interview with [client C]...Said on 8/21/15 she was mad at [client H] while attended (sic) [Day Services] concerning a boy. Said then when she [client C] got home from [name of Day Services] the staff started telling her what to do...Said she got mad because [name of staff] wanted her to take her medicine when she got home but she didn't want to take it. Said staff told her to go to her room but she didn't want to go to her room. Said she did not know why staff asked her to go to her room...[Client C] hit [staff] in the eye with an air freshener...then punched [staff] in the face breaking her (the staff's) glasses...staff responded by trying to put [the staff's] hands on [client C] like when [clients A and B] get PIA...[client C] said this made her mad and she fought back by continuing to punch [staff], said [staff] hit her back...[a different staff] got between them, [staff] tried to put her arm around her so [client C] bit her on the arm...[Client C] said she went to her room...then went outside and sat on the chair on the porch...[GHS #10] informed [client C] they had called the police...I</p>			

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	<p>pee'd on the chair and I didn't want to go to the Emergency Room...[Client C] said when the Police come (sic), I just sit (sic), and then they go away...."</p> <p>-The 8/21/15 investigation indicated an "Interview with [GHS #11]." GHS #11 indicated when she arrived at the Day Services to pick up clients, client C was "upset with [client H]...over a boy," and prompted client C to "stop yelling and calling [client H] names...[Client C] got on the van and then started to call both [staff] [profane names]." GHS #11 indicated client C continued to be verbally aggressive on the van on the way home from Day Services, upon arrival home "cursed very loudly...targeted [client H], telling [client H] that she was going to kill her and then she (client C) was going to kill herself...trying to cut herself with the back and forth action across her wrist with the headband...ran out of the house...threatened to kill her housemate which [client C] had never done before...threatening to kill herself...returned to the group home calling staff (profane names)...staff offered 4pm medications...[client C] refused, turned to [client D] and told [client D] she was fat" and client C became physically aggressive toward the staff.</p>			

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	<p>-The 8/21/15 investigation indicated an "Interview with [Client D]...said [client C] was screaming and yelling on the van...when they got home [client C] called her fat...said [client C] said she was going to kill [client H] and that she just kept calling me fat...said when [client C] began to throw things she [client D] went to her room...."</p> <p>-The 8/21/15 investigation indicated an "Interview with [Client H]...said [client C] was upset with her because she was talking to a guy friend of [client C's] right before transport. Said [client C] called [her] all kinds of things like b---- and wh---...Said when they got home [client C] said she was going to kill her...Said she [client H] stayed near staff in the living room as a result. Said [client C] was just out of control. [Client H] said she was scared...[client C] called [client D] fat...."</p> <p>The 8/21/15 investigation indicated "Evidence does not support the allegation of abuse."</p> <p>The 8/21/15 investigation did not include effective corrective measures and the investigation did not indicate recommendations as a result of the investigation. The investigation did not include investigating client C's threats of physical harm toward client H, reporting the threats of physical harm to BDDS and</p>			

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	<p>the Administrator, and corrective measures to ensure client H's safety.</p> <p>On 8/28/15 at 1:45pm, a review of client C's 8/26/15 "IDT (Interdisciplinary Team) Note" was reviewed. The 8/26/15 IDT indicated client C's BSP was reviewed regarding the 8/21/15 incident and "Targeted behaviors already address what took place. Those behaviors are as follows: Self Injurious behavior, Aggressive Outbursts, Verbal Aggression, False Reporting, Vacating, Physical Aggression. Plan reviewed and determined to be sufficient to address any future behaviors...."</p> <p>On 8/24/15 at 4:00pm, an interview was conducted with the PD/QIDP (Program Director/Qualified Intellectual Disabilities Professional). The PD/QIDP stated clients B and C "target" client H. The PD/QIDP indicated client H was smaller in her body build, sat in a wheelchair, and clients B and C were larger body builds, taller, and stronger than client H. The PD/QIDP stated the investigation was "in process" on 8/24/15 and had not been completed. The PD/QIDP indicated no corrective measures had been added to ensure client H's safety because no changes in client C's plans had been recommended.</p>			

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W 0186 Bldg. 00	<p>On 8/28/15 at 3:15pm, an interview with the AD was conducted. The AD indicated the 8/21/15 investigation did not indicate corrective action recommendations as a result of the investigation. The investigation did not include investigating client C's threats of physical harm toward client H, reporting the threats of physical harm to BDDS and the Administrator, and corrective measures to ensure client H's safety.</p> <p>This deficiency was cited on 7/1/2015. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN00176248.</p> <p>9-3-2(a)</p> <p>483.430(d)(1-2) DIRECT CARE STAFF 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 record review and interview, for 2 of 3 sampled clients (clients B and</p>	W 0186	Home Manager, QIDP and Area Director have met to review the current staffing schedule and	09/27/2015			

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	<p>H), the facility failed to ensure sufficient staff were available on duty at the group home to supervise and to implement client B and H's ISPs (Individual Support Plan), BSPs (Behavior Support Plan), and Risk Plans.</p> <p>Findings include:</p> <p>On 8/24/15 at 12:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed from 7/1/15 through 8/24/15. The review indicated the following:</p> <p>-A 7/12/15 BDDS report for an incident on 7/12/15 at 10:00am indicated "On Sunday, 7/12/15 at 10:00am, the Program Director was notified by the On Call Home Manager that [client B] was physically aggressive with her roommate [client H] in the Group Home over a bracelet that [client B] alleged had been stolen from her. Staff report they had to use Physical Intervention to get [client B] off of her roommate whom was having trouble defending herself while in her wheelchair." The report indicated clients B and H had no injuries noted.</p> <p>-The 7/28/15 completed "Summary of Internal Investigation Report" for the 7/12/15 incident indicated "...[Client B]</p>		<p>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.</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 received training on necessary staffing ratios while in the group</p>	

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	<p>has a history of physical aggression towards different housemates in her Group Home. The client has a history of false allegations that have been previously investigated." The "Factual Findings" indicated GHS (Group Home Staff) #4 "indicated [client H] came into the kitchen to get her breakfast and [client B] started an argument with [client H]. [Client B] claimed [client H] had on her necklace (sic)...[Client H] said that the necklace (sic) belonged to her and refused to give it [to client B], so they started arguing...[GHS #4] stated they were going to take the bracelet (sic) to calm down confusion about whose bracelet (sic) it was when [client B] grabbed [client H] and started twisting [client H's] arm vigorously. [Client H] started hollering. [GHS #4] did PIA (Physical Intervention Alternative) until [client B] calmed down. [Client B] continued to be verbally aggressive. [GHS #4] contacted the On Call Home Manager who came over and did a report."</p> <p>-The 7/28/15 investigation indicated "Upon interviewing the On Call House Manager [Name of person] stated that she arrived to the shift at 9:46am because she was informed via the telephone by [GHS #4] that there had just been an incident of PIA. [The On Call House Manager]</p>		<p>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.</p> <p>The staff that reported to work late received corrective action for reporting late to her shift. The staff that failed to report being alone with seven clients when and incident occurred between two consumers that required physical restraint being used by one client receive corrective action for failing to report the other staff coming in late and therefore not being able to fulfill the staffing ratios that had been put in place for client safety.</p> <p>All direct care staff received retraining on ensuring that if a situation arose when the designated staffing ratios could not be met, it was required to report to the on call supervisor so that immediate plans could be made to ensure additional staffing was available to maintain the ratios.</p>	

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	<p>stated that upon arrival she found that [GHS #4] was alone on shift...the 2nd (second) person working had not shown up and she wasn't sure who it was because a lot of different people were picking up shifts." The investigation indicated the second staff arrived at 10:31am and client B was "still visibly upset."</p> <p>-The 7/28/15 investigation indicated "Upon interviewing [client H], she stated [client B] let her [client H] borrow her white and blue bracelet with a matching necklace. [Client H] said that [client B] made it at the [name of day program] and she thought [client B] had given it to her. [Client H] stated that [client B] then started to rip it off her [client H's] arm and that's when [GHS #4] physically intervened. When [GHS #4] tried to come behind [client B], and get her arm and then they both fell back onto the floor. [Client H] said [client B] was screaming at the top of her lungs that [GHS #4] was beating on her, but that is not what happened. [Client H] said [GHS #4] was just trying to keep [client H] safe." Client H then requested a change of bedrooms since clients B and H had shared a room before the incident.</p> <p>-The 7/28/15 investigation indicated "When [client B] was interviewed, she</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. 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.</p> <p>Responsible Party: QIDP, Regional Quality Assurance Specialist, Area Director</p>	

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	<p>stated that she was choked by [GHS #4] and that [GHS #4] jumped on [client B's] back...When asked if she grabbed the bracelet off of [client H's] arm, [client B] said yes. When asked if she was grabbing it roughly, trying to get it off, [client B] said yes, but she didn't mean to. [Client B] said she just wanted her bracelet back and [client H] would not give it to her...(client B said) she knows [client H] is smaller than her and she would not hurt that girl...When asked why [client B] gave it to [client H] in the first place, going against the rules of sharing items with each other, [client B] stated because [client H] said she liked it but that she did not mean for [client H] to keep it forever."</p> <p>-The 7/28/15 investigation did not include a review of the staffing ratios for the group home and did not include the specific time frame when GHS #4 was left alone with seven clients.</p> <p>On 8/24/15 at 1:20pm, an interview was conducted with the Area Director (AD). The AD stated the facility "should have at least two (2)" staff members "on duty whenever the clients" in the group home were awake. The AD indicated clients B and C had identified behaviors of physical aggression, verbal aggression, and AWOL (Absent Without Leave) and</p>			

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	<p>stated "There should always be at least two staff present." The AD indicated on 7/12/15 clients B, C, D, E, F, G, and H were awake and in the kitchen when the incident occurred between clients B and H with one staff (GHS #4). The AD stated "No, the staff did not report to the On Call House Manager on 7/12/15 when the overnight staff person had left the group home and the second day shift staff was not on duty at the group home." The AD indicated GHS #3 received corrective action for reporting late to her shift and GHS #4 received corrective action for failing to immediately report being alone with seven clients. The AD indicated GHS #4 contacted the On Call House Manager to report client to client physical aggression between clients B and H which resulted in physical restraints being used on client B. The AD indicated the staff failed to report immediately to the administrator that sufficient staff were not present in the group home after 8am until 10:31am when GHS #3 arrived to the group home as the second staff person. The AD stated one staff on duty in the group home "cannot supervise" and/or implement clients B and H's ISP, BSP, and Risk Plans.</p> <p>On 8/24/15 at 2:45pm, client B's record was reviewed. Client B's 7/10/15 ISP</p>			

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	<p>(Individual Support Plan) and 7/10/15 BSP (Behavior Support Plan) included targeted behaviors of elopement behaviors, Physical Aggression, Verbal Aggression, Inappropriate Social Behavior, Excessive Consumption, and Resistance to Instruction. Client B's plans indicated she required twenty-four hour staff supervision.</p> <p>Client H's record was reviewed on 8/24/15 at 3:00pm and on 8/25/15 at 3:15pm. Client H's 10/31/14 ISP indicated the client's diagnoses included, but were not limited to the diagnosis of: Mild Mental Retardation and Spinal Bifid. Client H's record indicated she used a wheel chair for mobility. Client H's 7/10/15 BSP included the targeted behavior of False Reporting. Client H's plans indicated she required twenty-four hour staff supervision.</p> <p>This deficiency was cited on 7/1/2015. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN00176248.</p> <p>9-3-3(a)</p>			

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W 0249  Bldg. 00	<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 2 of 3 sampled clients (clients B and H), the facility failed to ensure client B and H's ISPs (Individual Support Plan), BSPs (Behavior Support Plan), and Risk Plans were implemented when formal and informal opportunities existed.</p> <p>Findings include:</p> <p>On 8/24/15 at 12:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed from 7/1/15 through 8/24/15. The review indicated the following for clients B and H:</p> <p>-A 7/12/15 BDDS report for an incident on 7/12/15 at 10:00am indicated "On Sunday, 7/12/15 at 10:00am, the Program Director was notified by the On Call Home Manager that [client B] was physically aggressive with her roommate [client H] in the Group Home over a bracelet that [client B] alleged had been stolen from her. Staff report they had to</p>	W 0249	<p>All direct care staff received retraining on ensuring that if a situation arose when the designated staffing ratios could not be met, it was required to report to the on call supervisor so that immediate plans could be made to ensure additional staffing was available to maintain the ratios and all consumer Behavior Support plans could be implemented as written.</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. 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</p>	09/27/2015

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	<p>use Physical Intervention to get [client B] off of her roommate whom was having trouble defending herself while in her wheelchair."</p> <p>-The 7/28/15 completed "Summary of Internal Investigation Report" for the 7/12/15 incident indicated "...[Client B] has a history of physical aggression towards different housemates in her Group Home." The "Factual Findings" indicated GHS (Group Home Staff) #4 "indicated [client H] came into the kitchen to get her breakfast and [client B] started an argument with [client H]. [Client B] claimed [client H] had on her necklace (sic)...[Client H] said that the necklace (sic) belonged to her and refused to give it [to client B], so they started arguing...[GHS #4] stated they were going to take the bracelet (sic) to calm down confusion about whose bracelet (sic) it was when [client B] grabbed [client H] and started twisting [client H's] arm vigorously. [Client H] started hollering. [GHS #4] did PIA (Physical Intervention Alternative) until [client B] calmed down. [Client B] continued to be verbally aggressive. [GHS #4] contacted the On Call Home Manager who came over and did a report."</p> <p>-The 7/28/15 investigation indicated</p>		<p>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.</p> <p>Responsible Party: QIDP, Regional Quality Assurance Specialist, Area Director</p>		

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	<p>"Upon interviewing the On Call House Manager [Name of person] stated that she arrived to the shift at 9:46am because she was informed via the telephone by [GHS #4] that there had just been an incident of PIA. [The On Call House Manager] stated that upon arrival she found that [GHS #4] was alone on shift...the 2nd (second) person working had not shown up and she wasn't sure who it was because a lot of different people were picking up shifts." The investigation indicated the second staff arrived at 10:31am and client B was "still visibly upset."</p> <p>-The 7/28/15 investigation indicated "Upon interviewing [client H], she stated [client B] let her [client H] borrow her white and blue bracelet with a matching necklace. [Client H] said that [client B] made it at the [name of day program] and she thought [client B] had given it to her. [Client H] stated that [client B] then started to rip it off her [client H's] arm and that's when [GHS #4] physically intervened. When [GHS #4] tried to come behind [client B], and get her arm and then they both fell back onto the floor. [Client H] said [client B] was screaming at the top of her lungs that [GHS #4] was beating on her, but that is not what happened. [Client H] said [GHS #4] was just trying to keep [client</p>			
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	<p>H] safe." Client H then requested a change of bedrooms since clients B and H had shared a room before the incident.</p> <p>-The 7/28/15 investigation indicated "When [client B] was interviewed, she stated that she was choked by [GHS #4] and that [GHS #4] jumped on [client B's] back...When asked if she grabbed the bracelet off of [client H's] arm, [client B] said yes. When asked if she was grabbing it roughly, trying to get it off, [client B] said yes, but she didn't mean to. [Client B] said she just wanted her bracelet back and [client H] would not give it to her...(client B said) she knows [client H] is smaller than her and she would not hurt that girl...When asked why [client B] gave it to [client H] in the first place, going against the rules of sharing items with each other, [client B] stated because [client H] said she liked it but that she did not mean for [client H] to keep it forever."</p> <p>On 8/24/15 at 1:20pm, an interview was conducted with the Area Director (AD). The AD stated the facility "should have at least two (2)" staff members "on duty whenever the clients" in the group home were awake. The AD indicated clients B and C had identified behaviors of physical aggression, verbal aggression, and AWOL (Absent Without Leave) and</p>			

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	<p>stated "There should always be at least two staff present." The AD indicated on 7/12/15 clients B, C, D, E, F, G, and H were awake and in the kitchen when the incident occurred between clients B and H with one staff (GHS #4). The AD indicated GHS #4 contacted the On Call House Manager to report client to client physical aggression between clients B and H which resulted in physical restraints being used on client B. The AD indicated the staff failed to implement client B's BSP to offer choices of activities, offer quiet time away from the area, and talking privately with the staff regarding why client B was upset. The AD stated one staff on duty in the group home "cannot supervise" and/or implement each client's ISP, BSP, and Risk Plans.</p> <p>On 8/24/15 at 2:45pm, client B's record was reviewed. Client B's 7/10/15 ISP (Individual Support Plan) and 7/10/15 BSP (Behavior Support Plan) included targeted behaviors of elopement behaviors, Physical Aggression, Verbal Aggression, Inappropriate Social Behavior, Excessive Consumption, and Resistance to Instruction. Client B's plans indicated she required twenty-four hour staff supervision. Client B's 7/10/15 BSP indicated "...Staff should be foster good working relationships with [client</p>			

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  08/28/2015
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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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	<p>B] making their time positive and reinforcing. Ensure that access to preferred items and activities whenever appropriate behavior is being displayed...Replacement Behavior... [Client B] know how to use and responds to deep breathing. When she appears upset, immediately request that she calm herself down and take deep breaths. She is often upset when her demands are not met, inform her that you can see she is frustrated and that you understand she is frustrated. Ask her to continue deep breaths. Offer her choices. Ask [client B] if she would like to take a break from others, have time alone to calm, or if she would like to talk to you. Praise her for any attempts at remaining calm...Response Measures: Aggressive Outburst. Prompt to stop, state Stop hitting now...Point or otherwise provide a clear gesture towards a preferred location or activity prior to observing further escalation. Prevent/block behavior from occurring/continuing by raising your arm in front of striking attempts, place hand over items so that it doesn't get thrown at others (damaged), use open hand to prevent Self Injurious behavior...One Arm Hold will be used if avoiding, blocking, or escorting does not work. The staff will make an "L" with one hand and restrict one of [client B's] arms. One Arm Hold to the Floor: same as the one</p>			

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	<p>arm hold but staff will use the 2nd "L" shaped hand to restrained [client B's] other flailing arm to her side...."</p> <p>Client H's record was reviewed on 8/24/15 at 3:00pm and on 8/25/15 at 3:15pm. Client H's record indicated she used a wheel chair for mobility. Client H's 7/10/15 BSP included the targeted behavior of False Reporting. Client H's plans indicated she required twenty-four hour staff supervision. Client H's 7/10/15 BSP indicated "...If [client H] is being verbally aggressive because an instruction was placed...replace the instruction in a calm and neutral tone...if [client H] is still being verbally aggressive then replace the instruction following through with the instruction using least to most prompting...False Reporting: Do not react emotionally to the accusation. Calmly tell [client H] that you will record what she has said...keep discussion to a minimum...."</p> <p>This deficiency was cited on 7/1/2015. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN00176248.</p> <p>9-3-4(a)</p>			

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

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FORM APPROVED

OMB NO. 0938-0391

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