

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G789	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/23/2015
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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3770 W 80 N KOKOMO, IN 46901
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W000000	<p>This visit was for the investigation of complaint #IN00162211.</p> <p>Complaint #IN00162211: SUBSTANTIATED, Federal and State deficiencies related to the allegations were cited at W102, W104, W122, W149, W153, W154, W157, and W189.</p> <p>Dates of Survey: 1/12, 1/13, 1/14, 1/20, 1/21, 1/22, and 1/23/2015.</p> <p>Provider Number: 15G789 AIM Number: 201012970 Facility Number: 012485</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/28/15 by Ruth Shackelford, QIDP.</p>	W000000		
W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</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>Based on observation, interview, and record review, the facility failed to meet the Condition of Participation: Governing Body for 2 of 3 sampled clients (clients A and C) and for 1 additional client (client E). The governing body failed to provide oversight and management to ensure the Condition of Participation: Client Protections was met. The Governing Body failed to ensure the facility implemented the facility's policy and procedures to protect clients A and E from their known behaviors of AWOL (Absent without Leave) and the potential of abuse, neglect, and/or mistreatment by the failure to ensure oversight of AWOL incidents, injuries of unknown source, to complete thorough investigations, and to ensure effective corrective action.</p> <p>Findings include:</p> <p>Please refer to W104. The governing body failed to provide administrative oversight of workshop services, failed to ensure the facility implemented the agency's policy and procedure to prevent abuse, neglect, and/or mistreatment for clients A, C, and E, to ensure staff supervision of clients A and E based on their identified needs, failed to ensure the reporting of injuries of unknown origin according to State Law for clients A and</p>	W000102	<p><b>a. Pleaserefer to W104.</b> <b>The governing body failed to provide administrative oversight ofworkshop services, failed to ensure the facility implemented the agency'spolicy and procedure to prevent abuse, neglect, and/or mistreatment for clientsA, C, and E, to ensure staff supervision of clients A and E based on theiridentified needs, failed to ensure the reporting of injuries of unknown originaccording to State Law for clients A and C, and failed to ensure thoroughinvestigations and effective actions were taken for clients A and C, and failedto ensure thorough investigations and effective corrective actions were takenfor clients A, C, and E for 2 of 20 reportable incidents reviewed".</b> <b>CorrectiveAction(s):</b> <b>Toensure that established effective administrative oversight and agency policiesand procedures for incident reporting, abuse, neglect, and mistreatment ofclients are implemented</b></p>	02/22/2015

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	<p>C, and failed to ensure thorough investigations and effective corrective actions were taken for clients A, C, and E for 2 of 20 reportable incidents reviewed.</p> <p>Please refer to W122. The governing body failed to meet the Condition of Participation: Client Protections for 2 of 3 sampled clients (clients A and C) and 1 additional client (client E). The governing body failed to implement their policy and procedures to protect clients A, C, and E from the potential of further abuse, neglect, and/or mistreatment by the failure to take proactive measures to ensure implementation of client A and E's individual plans, failed to immediately report according to State Law, and failed to thoroughly investigate client A, C, and E's incidents.</p> <p>This federal tag relates to complaint #IN00162211.</p> <p>9-3-1(a)</p>		<p><b>and executed as written, the following correctiveaction(s) will be implemented:</b></p> <p>1) Diagnosticand Evaluation forms (D&amp;E's) for all clients residing at 3770 North 80 West(Sycamore group home) will be reviewed and revisions to all Behavior SupportPlans (BSP) will be completed to reflect past information and presentinformation needed for continuity of care. BSP's will continually be revised touupdate any new targeted behaviors, incidents, or medical issues as they arise.Direct care staff will be promptly trained on any revisions or additions toindividual plans. Record of Training forms will completed once all trainingsare finalized.</p> <p>2) Administrativechecks will be completed daily, Monday-Friday and twice on Saturday and Sundayto ensure more administrative oversight in the home. All checks are documentedby the designated administrator on sign-in sheets located in the home.</p> <p>3) LeadDSP position will be implemented in all group homes within the</p>				

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			<p>Residential Services Department to ensure supervision seven (7) days a week and to ensure more administrative/supervisory oversight in the home.</p> <p>4) All staff located at 3770 North 80 West (Sycamore Group home) will be retrained on the agency accident/injury process and incident reporting as well as changes to the internal routing system for the above mentioned processes to ensure evaluation of all accident/injury and incident reports in a more timely manner. Record of training forms will be completed once trainings are finalized. <i>Refer to Appendix A and B for Record of Training forms to be used</i></p> <p>5) All Residential House Managers (RHM) and Qualified Intellectual Disabilities Professional (QIDP) within the Residential Services Department will be retrained on BDDS reportable guidelines, how to file a BDDS report, and evaluations for all accident/injury reports to ensure a higher level of monitoring with all incidents.</p>	

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			<p>Record of training forms will be completed as all trainings are finalized. <i>Refer to Appendix C for Record of Training form to be used.</i></p> <p>6) All Qualified Intellectual Disabilities Professionals (QIDP) within the Residential Services Department will office out of the same building as the Residential Director and Residential Vice President to provide continuous and more thorough administrative oversight in their work. Additionally, the QIDP will spend a designated amount of time each day in their assigned group home to provide one-on-one interaction with the clients and to help administrative staff determine how we may better meet individual client needs.</p> <p><b><i>b. "Please refer to W122. The governing body failed to meet the Condition of Participation: Client Protections for 2 of 3 sampled clients (clients A and C) and 1 additional client (client E). The governing body failed to</i></b></p>	

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			<p><i>implement their policy and procedures to protect clients A, C, and E from the potential of further abuse, neglect, and/or mistreatment by the failure to take proactive measures to ensure implementation of Client A and E's individual plans, failed to immediately report according to State Law, and failed to thoroughly investigate client A, C, and E's. "</i></p> <p><b>Corrective Action(s):</b></p> <p><b>To ensure implementation of individual plans and that established agency policies and procedures for abuse, neglect, and incident reporting are being implemented and executed as written, the following corrective action(s) will be implemented:</b></p> <p>1) Diagnostic and Evaluation forms (D&amp;E's) for all clients residing at 3770 North 80 West (Sycamore group home) will be reviewed and revisions to all Behavior Support Plans (BSP) will be completed to reflect past information and present information needed for</p>		

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			<p>continuity of care. BSP's will continually be revised to update any new targeted behaviors, incidents, or medical issues as they arise. Direct care staff will be promptly trained on any revisions or additions to individual plans. Record of Training forms will be completed once all trainings are finalized.</p> <p>2) All staff located at 3770 North 80 West (Sycamore Group home) will be retrained on the agency accident/injury process and incident reporting as well as changes to the internal routing system for the above mentioned processes to ensure evaluation of all accident/injury and incident reports in a more timely manner. Record of training forms will be completed once trainings are finalized. <i>Refer to Appendix A and B for Record of Training forms to be used</i></p> <p>3) All Residential House Managers (RHM) and Qualified Intellectual Disabilities Professional (QIDP) within the Residential Services Department will be retrained on BDDS reportable guidelines, how to file a</p>	

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W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review, and interview, for 2 of 20 incidents reviewed for 3 of 8 clients (clients A, C, and E), the governing body failed to provide administrative oversight of workshop services, failed to ensure the facility implemented the agency's policy and procedure to prevent abuse, neglect, and/or mistreatment for clients A, C, and E to ensure staff supervision of clients A and E based on their identified needs, failed to ensure the reporting of injuries of unknown origin according to State Law for clients A and C, and failed to ensure thorough investigations and effective corrective actions were taken for clients A, C, and E.</p> <p>Findings include:</p>	W000104	<p>BDDS report, and evaluations for all accident/injury reports to ensure a higher level of monitoring with all incidents. Record of training forms will be completed as all trainings are finalized. Refer to Appendix C for Record of Training form to be used.</p> <p><b>a. "Please refer to W149. The governing body failed for 2 of 20 reportable incidents reviewed and 2 of 2 injuries of unknown source for 3 of 8 clients (clients A, C, and E), to ensure implementation of the agency's policies and procedures for abuse, neglect, and/or mistreatment for clients A, C, and E, failed to ensure staff supervision of clients A and E based on their identified needs, failed to report injuries of unknown origin according to State Law for clients A and C, and failed to complete thorough investigations for clients A, C,</b></p>	02/22/2015

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	<p>Please refer to W149. The governing body failed for 2 of 20 reportable incidents reviewed and 2 of 2 injuries of unknown source for 3 of 8 clients (clients A, C, and E), to ensure implementation of the agency's policies and procedures for abuse, neglect, and/or mistreatment for clients A, C, and E, failed to ensure staff supervision of clients A and E based on their identified needs, failed to report injuries of unknown origin according to State Law for clients A and C, and failed to complete thorough investigations for clients A, C, and E, and to complete effective corrective action.</p> <p>Please refer to W153. The governing body failed to immediately report 2 of 2 injuries of unknown source reviewed for 2 of 8 clients (clients A and C), to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law.</p> <p>Please refer to W154. The governing body failed to document a thorough investigation for 2 of 20 incidents reviewed and for 2 of 2 injuries of unknown origin for 3 of 8 clients (clients A, C and E).</p> <p>Please refer to W157. The governing body failed for 2 of 20 reportable incidents reviewed for 2 of 8 clients (clients A and E), to complete effective</p>		<p><b>and E and tocomplete effective corrective action”.</b></p> <p><b>CorrectiveAction(s):</b></p> <p><b>Toensure that established agency policies and procedures for investigations,abuse, neglect, and incident reporting is being implemented and executed aswritten, the following corrective action(s) will be implemented:</b></p> <p>1) Allstaff located at 3770 North 80 West (Sycamore Group home) will be retrained onthe agency accident/injury process and incident reporting as well as changes tothe internal routing system for the above mentioned processes to ensureevaluation of all accident/injury and incident reports in a more timely manner.Record of training forms will be completed once trainings are finalized. <i>Refer to Appendix A and B for Record ofTraining forms to be used</i></p> <p>2) AllResidential House Managers (RHM) and Qualified Intellectual DisabilitiesProfessionals (QIDP) within the Residential Services Department will be</p>	

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	<p>corrective action for clients A and E to address incidents of elopement.</p> <p>This federal tag relates to complaint #IN00162211.</p> <p>9-3-1(a)</p>		<p>retrained on BDDS reportable guidelines, how to file a BDDS report, and evaluations for all accident/injury reports to ensure a higher level of monitoring with all incidents. Record of training forms will be completed as all trainings are finalized. <i>Refer to Appendix C for Record of Training form to be used.</i></p> <p>3) All investigations will be conducted in the manner outlined on the Residential Services Investigation Process. <i>Refer to Appendix D for process outline.</i> To ensure that all investigations are conducted in a uniform and consistent manner, all Residential House Managers, Qualified Development Disability Professionals, Nurses, the Director, and the Residential Services Coordinator will be trained on the newly established investigation process outline. <i>Refer to Appendix E for Record of Training form to be used in documenting training.</i></p> <p><b>b. "Please refer to W153.</b></p>		

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			<p><i>The governing body failed to immediately report 2 of 2 injuries of unknown source reviewed for 2 of 8 clients (clients A and C), to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law".</i></p> <p><b>Corrective Action(s):</b>  <b>To ensure that established agency policies and procedures for incident reporting is being implemented and executed as written, the following corrective action(s) will be implemented:</b></p> <p>1) All staff located at 3770 North 80 West (Sycamore Group home) will be retrained on the agency accident/injury process and incident reporting as well as changes to the internal routing system for the above mentioned processes to ensure evaluation of all accident/injury and incident reports in a more timely manner. Record of training forms will be completed once trainings are finalized. <i>Refer to Appendix A and B for Record of Training forms to be used.</i></p>	

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			<p>2) All Residential House Managers (RHM) and Qualified Intellectual Disabilities Professionals (QIDP) within the Residential Services Department will be retrained on BDDS reportable guidelines, how to file a BDDS report, and evaluations for all accident/injury reports to ensure a higher level of monitoring with all incidents. Record of training forms will be completed as all trainings are finalized. <i>Refer to Appendix C for Record of Training form to be used.</i></p> <p>c. <i>“Please refer to W154. The governing body failed to document a thorough investigation for 2 of 20 incidents reviewed and for 2 of 20 incidents reviewed and for 2 of 2 injuries of unknown origin for 3 of 8 clients (clients A, C, and E). Corrective Action(s): To ensure that established agency policies and procedures for investigations are being implemented and executed as written, the following corrective</i></p>		

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			<p><b>action(s) will be implemented:</b></p> <p>1) All investigations will be conducted in the manner outlined on the Residential Services Investigation Process. <i>Refer to Appendix D for process outline.</i> To ensure that all investigations are conducted in a uniform and consistent manner, all Residential House Managers, Qualified Development Disability Professionals, Nurses, the Director, and the Residential Services Coordinator will be trained on the newly established investigation process outline. <i>Refer to Appendix E for Record of Training form to be used in documenting training.</i></p> <p><b>d. "Please refer to W157. The governing body failed for 2 of 20 reportable incidents reviewed for 2 of 8 clients (clients A and E), to complete effective corrective action for clients A and E to address incidents of elopement.</b></p> <p><b>Corrective Action(s):</b></p>	

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			<p><b>Toensure effective corrective action for clients based on their individual needs,the following corrective action(s) will be implemented:</b></p> <p>1) Diagnosticand Evaluation forms (D&amp;E's) for all clients residing at 3770 North 80 West(Sycamore group home) will be reviewed and revisions to all Behavior SupportPlans (BSP) will be completed to reflect past information and presentinformation needed for continuity of care. BSP's will continually be revised touptdate any new targeted behaviors, incidents, or medical issues as they arise.Direct care staff will be promptly trained on any revisions or additions toindividual plans. Record of Training forms will completed once all trainingsare finalized.</p> <p>2) Theagency has purchased a cellular phone for client A. The contact numbers for theagency administrative office, the Sycamore group home in which he resides, theResidential House Manager, Qualified Intellectual Disabilities Professional,and the Director</p>	

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			<p>of Residential Services were programmed into phone. A plan was implemented in which client A carries the phone with him at all times and informal goals are being implemented to show him how to correctly use his phone. The use of the phone has also been added to the Behavioral Support Plan(BSP). The phone also has "5 star" capabilities in which an emergency dispatch system is contacted when the designated button is pushed. The contact information for the Qualified Intellectual Disabilities Professional and Director of Residential Services was provided to the dispatch service as emergency contacts.</p> <p>3) Client E has been placed in a physician ordered wheel chair and requires staff supervision and assistance with all transfers. The QIDP has created and implemented a <i>Workshop Falling Plan</i>, <i>Falling Management Plan</i>, and a <i>Transferring plan</i>. All workshop staff as well as staff located at 3770 North 80 West (Sycamore group home) will</p>	

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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview, and record review, the facility failed to meet the Condition of Participation: Client Protections for 2 of 3 sampled clients (clients A and C) and 1 additional client (client E). The facility failed to implement their policy and procedures to protect clients A, C, and E from the potential of further abuse, neglect, and/or mistreatment by the failure to take proactive measures to ensure implementation of client A and E's individual plans, failed to immediately report according to State Law, failed to thoroughly investigate client A, C, and E's incidents and lack of staff oversight to ensure supervision of clients A, C, and E.</p> <p>Findings include:</p> <p>Please refer to W149. The facility neglected for 2 of 20 reportable incidents reviewed and 2 of 2 injuries of unknown source for 3 of 8 clients (clients A, C, and E), to ensure implementation of the</p>	W000122	<p>betraigned on all plans. Record of training forms will be completed as trainingsare finalized.</p> <p><i>a. "Pleaserefer to W149. The facility neglected for 2 of 20 reportable injuries of unknown source for 3 of 8 clients (clients A, C, and E), to ensureimplementation of agency's policies and procedures for abuse, neglect, and/or mistreatment for clients A, C, and E, neglected to ensure staff supervision ofclients A and E based on their identified needs, neglected to report injuriesof unknown origin according to State Law for clients A and C, and neglected tocomplete thorough investigations for clients A, C, and E, and to completethorough investigations for clients A, C, and E, and to complete effectivecorrective action". CorrectiveAction(s): Toensure implementation of</i></p>	02/22/2015

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	<p>agency's policies and procedures for abuse, neglect, and/or mistreatment for clients A, C, and E, neglected to ensure staff supervision of clients A and E based on their identified needs, neglected to report injuries of unknown origin according to State Law for clients A and C, and neglected to complete thorough investigations for clients A, C, and E, and to complete effective corrective action.</p> <p>Please refer to W153. The facility failed to immediately report 2 of 2 injuries of unknown source reviewed for 2 of 8 clients (clients A and C), to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law.</p> <p>Please refer to W154. The facility failed to document a thorough investigation for 2 of 20 incidents reviewed and for 2 of 2 injuries of unknown origin for 3 of 8 clients (clients A, C and E).</p> <p>Please refer to W157. The facility failed for 2 of 20 reportable incidents reviewed for 2 of 8 clients (clients A and E), to complete effective correction action for clients A and E to address incidents of elopement.</p> <p>This federal tag relates to complaint #IN00162211.</p>		<p><b>individual plans and that established agency policies and procedures for abuse, neglect, and incident reporting are being implemented and executed as written, the following corrective action(s) will be implemented:</b></p> <p>1) Diagnostic and Evaluation forms (D&amp;E's) for all clients residing at 3770 North 80 West (Sycamore group home) will be reviewed and revisions to all Behavior Support Plans (BSP) will be completed to reflect past information and present information needed for continuity of care. BSP's will continually be revised to update any new targeted behaviors, incidents, or medical issues as they arise. Direct care staff will be promptly trained on any revisions or additions to individual plans. Record of Training forms will be completed once all trainings are finalized.</p> <p>2) All staff located at 3770 North 80 West (Sycamore Group home) will be retrained on the agency accident/injury process and incident reporting as well as changes to the</p>				

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	9-3-2(a)		<p>internal routing system for the above mentioned processes to ensure evaluation of all accident/injury and incident reports in a more timely manner. Record of training forms will be completed once trainings are finalized. <i>Refer to Appendix A and B for Record of Training forms to be used</i></p> <p>3) All Residential House Managers (RHM) and Qualified Intellectual Disabilities Professional (QIDP) within the Residential Services Department will be retrained on BDDS reportable guidelines, how to file a BDDS report, and evaluations for all accident/injury reports to ensure a higher level of monitoring with all incidents. Record of training forms will be completed as all trainings are finalized. <i>Refer to Appendix C for Record of Training form to be used.</i></p> <p><b><i>b. "Please refer to W153. The facility failed to immediately report 2 of 2 injuries of unknown source reviewed for 2 of 8 clients (clients A and C), to BDDS</i></b></p>		

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			<p><b><i>(Bureau of Developmental Disabilities Services) in accordance with State Law”.</i></b></p> <p>1) Allstaff located at 3770 North 80 West (Sycamore Group home) will be retrained onthe agency accident/injury process and incident reporting as well as changes tothe internal routing system for the above mentioned processes to ensureevaluation of all accident/injury and incident reports in a more timely manner. Record of training forms will be completed once trainings are finalized. <i>Refer to Appendix A and B for Record of Training forms to be used</i></p> <p>2) AllResidential House Managers (RHM) and Qualified Intellectual DisabilitiesProfessional (QIDP) within the Residential Services Department will be retrainedon BDDS reportable guidelines, how to file a BDDS report, and evaluations forall accident/injury reports to ensure a higher level of monitoring with allincidents. Record of training forms will be completed as all trainings</p>		

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			<p>arefinalized. <i>Refer to Appendix C for Recordof Training form to be used.</i></p> <p><b>c. "Please refer to W154. The facility failed to documenta thorough investigation for 2 of 20 incidents reviewed and for 2 of 2 injuriesof unknown origin for 3 of 8 clients (clients A, C, and E)".</b></p> <p><b>CorrectiveAction(s):</b>  <b>Toensure that established agency policies and procedures for investigations arebeing implemented and executed as written, the following corrective action(s)will be implemented:</b></p> <p>1) Allinvestigations will be conducted in the manner outlined on the ResidentialServices Investigation Process. <i>Refer toAppendix D for process outline.</i> To ensure that all investigations areconducted in a uniform and consistent manner, all Residential House Managers,Qualified Development Disability</p>		

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			<p>Professionals, Nurses, the Director, and the Residential Services Coordinator will be trained on the newly established investigation process outline. <i>Refer to Appendix E for Record of Training form to be used in documenting training.</i></p> <p><b><i>d. "Please refer to W157. The facility failed for 2 of 20 reportable incidents reviewed for 2 of 8 clients (clients A and E), to complete effective correction action for clients A and E to address incidents of elopement".</i></b></p> <p><b>Corrective Action(s):</b>  <b>To ensure effective corrective action for clients based on their individual needs, the following corrective action(s) will be implemented:</b></p> <p>1) Diagnostic and Evaluation forms (D&amp;E's) for all clients residing at 3770 North 80 West (Sycamore group home) will be reviewed and revisions to all Behavior Support Plans (BSP) will be completed to reflect past information and present information needed for</p>		

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			<p>continuity of care. BSP's will continually be revised to update any new targeted behaviors, incidents, or medical issues as they arise. Direct care staff will be promptly trained on any revisions or additions to individual plans. Record of Training forms will be completed once all trainings are finalized.</p> <p>2) The agency has purchased a cellular phone for client A. The contact numbers for the agency administrative office, the Sycamore group home in which he resides, the Residential House Manager, Qualified Intellectual Disabilities Professional, and the Director of Residential Services were programmed into the phone. A plan was implemented in which client A carries the phone with him at all times and informal goals are being implemented to show him how to correctly use his phone. The use of the phone has also been added to the Behavioral Support Plan (BSP). The phone also has "5 star" capabilities in which an emergency dispatch system is contacted when the</p>	

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W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review, and interview, for 2 of 20 incidents and 2 of 2 injuries of unknown source reviewed for 3 of 8 clients (clients A, C, and E), the facility neglected to implement the	W000149	designated button is pushed. The contact information for the Qualified Intellectual Disabilities Professional and Director of Residential Services was provided to the dispatch service as emergency contacts. 3) Client E has been placed in a physician ordered wheel chair and requires staff supervision and assistance with all transfers. The QIDP has created and implemented a <i>Workshop Falling Plan</i> , <i>Falling Management Plan</i> , and a <i>Transferring plan</i> . All workshop staff as well as staff located at 3770 North 80 West (Sycamore group home) will be trained on all plans. Record of training forms will be completed as trainings are finalized.  <b>To ensure that established agency policies and procedures for investigations, abuse, neglect, and incident reporting is</b>	02/22/2015

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	<p>agency's policy and procedure to prevent abuse, neglect, and/or mistreatment by neglecting to ensure implementation of the agency's policies and procedures for abuse, neglect, and/or mistreatment for clients A, C, and E, neglected to ensure staff supervision of clients A and E based on their identified needs, neglected to report injuries of unknown origin according to State Law for clients A and C, and neglected to complete thorough investigations for clients A, C, and E, and to complete effective corrective action.</p> <p>Findings include:</p> <p>1. On 1/12/15 at 1:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and included the following incidents for client A's AWOL (Absent Without Leave) behaviors:</p> <p>-A 1/1/15 BDDS report for an incident on 1/1/15 at 1:19pm, indicated the Residential Manager (RM) was notified by the staff "that [client A] had eloped from the group home. The [name of city] Police brought [client A] back to the group home around 1:35pm. [name of city] dispatch had received a phone call at 1:19pm, that an individual was sitting in a yard. Police arrived on the scene at 1:31pm, [client A] had informed the</p>		<p><b>being implemented and executed aswritten, the following corrective action(s) will be implemented:</b></p> <p>1) Allstaff located at 3770 North 80 West (Sycamore Group home) will be retrained onthe agency accident/injury process and incident reporting as well as changes tothe internal routing system for the above mentioned processes to ensureevaluation of all accident/injury and incident reports in a more timely manner.Record of training forms will be completed once trainings are finalized. <i>Refer to Appendix A and B for Record ofTraining forms to be used</i></p> <p>2) AllResidential House Managers (RHM) and Qualified Intellectual DisabilitiesProfessionals (QIDP) within the Residential Services Department will be retrainedon BDDS reportable guidelines, how to file a BDDS report, and evaluations forall accident/injury reports to ensure a higher level of monitoring with allincidents. Record of training forms will be completed as all trainings</p>		

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	<p>Police he made sure his shoes and coat was (sic) on before leaving because it was cold outside. [Client A] was down the road from his group home." The report indicated the staff were suspended on 1/1/15 after the incident was reported. The report indicated the staff were to check the door alarms every 15 minutes "to ensure they were working."</p> <p>-A 1/9/15 Follow up BDDS report indicated "APS (Adult Protective Services) substantiated neglect on the staff...The door alarms were turned off. We now have double alarms on all interior/exterior doors and have implemented every 15 minute safety checks to ensure the alarms are on and in working condition...It is believed [client A] was gone for about 1 hour 5 minutes...New goals have been implemented for teaching tools in regards to eloping without staff and the dangers, a cell phone has been purchased for him to call the Residential Manager (or other leadership agency staff) to talk instead of eloping...."</p> <p>-A 1/3/15 "Investigation" for client A's 1/1/15 incident indicated "two staff were working (at the group home) and were unaware of [client A's] whereabouts." The investigation indicated at "approximately 12:30pm, [client A]</p>		<p>arefinalized. <i>Refer to Appendix C for Record of Training form to be used.</i></p> <p>3) All investigations will be conducted in the manner outlined on the Residential Services Investigation Process. <i>Refer to Appendix D for process outline.</i> To ensure that all investigations are conducted in a uniform and consistent manner, all Residential House Managers, Qualified Development Disability Professionals, Nurses, the Director, and the Residential Services Coordinator will be trained on the newly established investigation process outline. <i>Refer to Appendix E for Record of Training form to be used in documenting training.</i></p>	

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	<p>became upset when he asked a staff member if he could go outside and smoke a cigarette and they asked him to wait for a few minutes because they were in the middle of counting consumer money... [Client A] eloped from the home without staff knowledge while both staff members working were in the med (medication) room...During the time [client A] was away from the home he sat down outside in someone's yard and the individual at that residence contacted the police." The investigation indicated client A was gone "for approximately 1 hour, when the police brought him back to the group home...Neither staff working at the time of the elopement knew [client A] had even left until [client A] was brought home by the police."</p> <p>-A 9/11/14 BDDS report for an incident on 9/10/14 at 6:05pm, indicated "Around 6:08pm, a neighbor notified staff that [client A] was walking down the road. Staff were unaware that [client A] had left the home. They immediately began to look for him." At 6:45pm, client A was located "about a mile away from the home, sitting on the corner of 400 West and State Road 22." The report indicated client A was not injured "but wet from the rain." The report indicated client A was "upset over some food items." The report indicated client A "had an</p>			

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	<p>elopement plan in place and the home has window and door alarms. These alarms will be checked to ensure that they are in proper working conditions."</p> <p>-The 9/11/14 Investigation for client A's 9/10/14 incident indicated client A eloped from the group home "without staffs (sic) knowledge" after becoming "upset at staff when he was asked to clean up his dishes from dinner so he went to his room and stayed there for some time." The investigation indicated "the allegations of neglect are unsubstantiated. Consumer [client A] has a history of elopement on a regular basis." The investigation indicated two (2) staff were on duty with eight (8) clients in the group home.</p> <p>-GHS (Group Home Staff) #8's 9/11/14 witness statement indicated two staff were at the group home during client A's 9/10/14 elopement incident. GHS #8 stated "I think we kinda (sic) realized at the same time. I went into [client A's] bedroom...I realized [client A] wasn't in his bed. [GHS #7] came in and said some guy came and told her one of our consumers was walking down the road. By the time I got to tell [client C] that I needed to check on someone, [GHS #7] was coming in saying some guy was telling [client C]." GHS #8 stated it was</p>						

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	<p>"about 6:10 (no am or pm was indicated)" and GHS #7 was pulling out of the driveway in the van to go look for client A. GHS #8 indicated she called the police to report client A missing after the Group Home Manager called to tell her to call the police.</p> <p>Client A's record was reviewed on 1/12/15 at 7:30pm and on 1/13/15 at 10:45am. Client A's 5/1/14 ISP (Individual Support Plan) and 5/2014 BSP (Behavior Support Plan) both indicated client A had targeted behaviors of Elopement. Client A's plans indicated staff were to provide twenty-four hour supervision. Client A's diagnoses included, but were not limited to: Major Depression, Seizure Disorder, Cerebral Palsy, and Pain Disorder. Client A's 5/1/14 "Elopement Plan" indicated when client A elopes "it is because he is upset...staff will be aware of this and keep [client A] within line of sight at all times...[client A] requires 24 hour awake staff, and must remain within line of sight any time that he is in the community...." Client A's Elopement Plan indicated he was at risk for falls, seizures, and for his safety. Client A's 5/1/14 "Capacity for Independence/Informed Consent" assessment indicated client A does not recognize danger when upset and</p>			

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	<p>required supervision in the community. Client A was not independent with money or medications, and did not have independent pedestrian safety skills. Client A's assessment indicated the agency staff assist client A to make decisions of informed consent.</p> <p>On 1/13/15 at 1:00pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Vice President of Residential Services (VPRS) was conducted. The QIDP and the VPRS both indicated staff neglected to supervise client A according to his identified needs. The QIDP indicated client A was not independent in the community and needed staff to supervise him while in the community. The QIDP indicated client A's Elopement plan indicated staff were to have kept client A within line of sight when he becomes upset to prevent client A's AWOL/Elopement behavior and staff did not implement client A's plans on 1/1/15 or on 9/10/14. The VPRS indicated the facility followed the BDDS policy and procedure for allegations of abuse, neglect, and/or mistreatment. The VPRS indicated neglect was the failure to provide sufficient staff supervision based on identified behaviors.</p> <p>On 1/12/15 from 4:00pm until 5:45pm,</p>						

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	<p>client A was observed at the group home and did not have an operational cell phone. At 4:15pm, client A indicated he left the group home without staff on 1/1/15 after he became upset with a staff. Client A indicated he did not have a cell phone for his use.</p> <p>2. On 1/12/15 at 1:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and included the following incident of client E's AWOL (Absent Without Leave) behaviors:</p> <p>-A 1/2/15 BDDS report for an incident on 1/2/15 at 9:15am, indicated client E's "immediate Supervisor observed [client E] leaving his work area to use the restroom. She stated that he is not good about notifying her when he needs to leave to go to the restroom. When he did not return in what was the normal amount of time for him to be gone she informed a co worker that she had a walkie talkie and was going to go look for him. He was not in the restroom...The supervisor walked to the cafeteria to see if he was (there)...and she found him in the hallway between the cafeteria and the workshop (at the back of the building)...[Client E] stated that he went to the bathroom and then went to the back door and there was a 'big black guy that I've never seen'</p>			

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	<p>standing near it but that he let himself out (of the building). [Client E] said after he got done smoking he just waited until someone come by to let him in. He did not know who let him in...." The report indicated client E "was reminded that he can only go out to smoke during designated smoke breaks when staff are out there to supervise."</p> <p>On 1/12/15 at 1:35pm, a 1/2/15 "Investigation" for client E's incident was reviewed. The investigation was a one and one half page narrative from the investigator, did not include witness statements, the questions asked during the investigation, who completed the investigation, if the investigation was reviewed for administrative oversight, any documents reviewed to complete the investigation, corrective measures, and the environmental conditions during the incident. The investigation indicated the events, that staff were suspended, "Since line of sight supervision is not required for [client E] and he is able to go to and from the restroom on his own, it is not believed that [the staff name] was neglectful in providing adequate supervision....[Client E] was also reminded that there are breaks when into his day and those are the times he should be going to have a cigarette."</p>			

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	<p>On 1/12/15 at 1:35pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) for the group home, the Vice President of Residential Services (VPRS), the Workshop Director (WD), and the Workshop Investigator (WI) was conducted. The QIDP and the VPRS both stated client E was to have "direct eye sight supervision by the facility staff when outside the group home, in the community, and while smoking." The QIDP and the VPRS both stated client E was not independent in the community regarding his safety, had had falls "frequently," and required the supervision of the staff while outside the workshop. The QIDP and the VPRS both indicated they did not review investigations completed at the workshop because the workshop leadership was in charge to complete investigations of incidents which occurred at the workshop. The QIDP and the VPRS both stated they "did not have" the investigation of client E's AWOL at the workshop. The WD and the WI both stated "the workshop completed their own investigations" for incidents which occur at the workshop. The WD stated the regulation "does not mandate a thorough investigation, only that an investigation be completed." The WD indicated it was acceptable practice for the investigator to paraphrase what the</p>			

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	<p>staff and client said regarding the incident. The WD stated witness statements should be documented, the witnesses do not need to write out their own statements "It's needless paperwork, it's time consuming." The WD and WI both stated the investigator was "the only person" at the workshop who reviews her own investigations. The WD and the WI both indicated the investigation did not include witness statements, an incident report, if the investigation was reviewed for administrative oversight, any documents reviewed to complete the investigation, corrective measures, and did not review the environmental conditions during the incident. Both staff indicated the investigation did not include who the man was client E indicated he let into the back of the building through the security door. The WD indicated there was a door bell at the rear of the workshop and he was unsure if the bell was operational. The WI indicated she did not review client E's Behavior Plan or Individual Support Plan to ensure what level of supervision he required.</p> <p>Client E's record was reviewed on 1/13/15 at 9:00am. Client E's 9/26/14 ISP (Individual Support Plan) and 9/2014 BSP (Behavior Support Plan) indicated Client E required twenty-four hour staff</p>			

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	<p>supervision. Client E's diagnoses included, but were not limited to: Schizophrenia, Intermittent Explosive Disorder, Oppositional Defiant Disorder, ADHD (Attention Deficient Hyperactivity Disorder), and Severe Communication Disorder with Apraxia. Client E's 12/10/14 "Hydrocephalus Plan" indicated Hydrocephalus is an atrophy of fluid around the brain. "Hydrocephalus is the abnormal accumulation of cerebrospinal fluid, usually under increased pressure in the skull, in ventricles of the brain. Symptoms of Hydrocephalus can include: short term memory loss, motion and visual difficulties, shuffling of the feet, difficulty walking, coordination difficulties, slower than normal movements, and poor balance." Client E's 12/3/14 "Falling Management Plan" indicated Client E had a "current history of falling" and a "traumatic brain injury" 20 years ago from a car accident. Client E's Hydrocephalus Plan and Fall Plan both indicated staff were to help Client E identify situations and hazards that can cause accidents to increase Client E's awareness of potential for falls and staff were to assist Client E while walking if unsteady and be "aware" when Client E was walking.</p> <p>During observations on 1/12/15 from</p>			

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	<p>4:00pm until 5:45pm, Client E was observed at the group home. At 5:30pm, client E indicated he recalled the incident at the workshop. Client E indicated he wanted a cigarette, went outside the workshop, and the security door locked behind him. Client E stated he "beat on the door with his fist awhile and finally someone came (to the door) after 20-25 minutes." Client E indicated it was cold outside. From 5:00pm until 5:10pm, client E was outside alone smoking without facility staff. From 5:30pm until 5:45pm, client E was outside alone smoking without facility staff.</p> <p>Client E's record included the following incidents (not all inclusive): -A 11/21/14 BDDS report for an incident on 11/20/14 at 6:30pm, indicated Client E "had fallen on 11/12/14 while at the workshop." Client E was taken to a walk in clinic for an X-ray of his right elbow due to falling on his right side on 11/12/14. There were no findings on the X-ray. There was a bruise that appeared later as a result of this fall on 11/12/14 that measured 7.9 inches long and 3.5 inches wide. The report indicated "on 11/20/14 [Client E] had complaints of left side weakness, left arm numbness, and his head not feeling right. Residential nurse immediately call (sic) [Client E's] GP (General Practitioner) left</p>						

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	<p>a message of the change in condition and took [Client E] to the walk in clinic. [Client E's] GP ordered a CT scan (a scan of the head)" and sent Client E to the hospital for evaluation and the scan. Client E's lab work and scan "checked out fine." The report indicated Client E had "no medical reason for falling. [Client E] has a prior diagnosis of Traumatic Brain Injury from a car wreck over 20 years ago."</p> <p>-A 11/25/14 Follow up BDDS report for the incident on 11/20/14 indicated Client E's 7.9 inch by 3.5 inch bruise was "on his right forearm/elbow area and a bruise on his left eye."</p> <p>-A 12/3/14 Follow up BDDS report indicated Client E went for an MRI (Magnetic Resonance Imaging) scan of his body organs at the hospital.</p> <p>On 12/16/14 at 1:25pm, a 11/21/14 Investigation into Client E's 11/20/14 incident indicated "Investigation of Significant Injury...Due to falls that allegedly occurred at the workshop [Client E] had a bruise on his right elbow that measured 7.9 inches long and 3.5 inches wide. [Client E] then started to complain that the left side of his body was numb and there was something wrong with his head." The following</p>						

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	<p>were included in the investigative documents:</p> <p>-A 11/20/14 "Physician's Statement" of visit for "Unsteady gait, dizziness, numbness left leg/arm. Go to [name of hospital] Radiology for STAT (immediate) CT Scan."</p> <p>-A 11/20/14 "CT Scan" results indicated "Atrophy of the cerebella hemispheres is noted...The findings are suspicious for communicating hydrocephalus. No evidence of acute intracranial hemorrhage, infarction or mass effect is noted...." Referred to ER (Emergency Room) for further evaluation.</p> <p>-A 11/20/14 "Physician's Statement" of visit for "ER Hydrocephalus" and referral made to see a neurologist.</p> <p>-A 11/18/14 visual services assessment completed by Client E's eye doctor for a "vision exam d/t (due to) L (left) eye injury, redness, itching. Subconjunctival hemorrhage. Artificial tears QID (four times a day), cool compresses as needed for comfort."</p> <p>-The "Day Services Nursing Documentation" log from the facility owned workshop indicated the following falls and information from 11/10/14</p>						

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	<p>through 11/12/14. Client E fell on 11/12/14 at 9:46am. Client E fell in hallway at break and refused to be looked at on 11/10/14 at 10:42am. On 11/10/14 at 11:55am, Client E requested "as needed" pain medication.</p> <p>-A 11/12/14 no hour documented "AM" checked, indicated "Workshop staff reported [Client E] had fallen at work and [the group home staff] took [Client E] to [walk in clinic]." Client E's 11/12/14 Walk In Clinic Doctor visit indicated "11/12/14...Reason for visit: Pt. (Patient) states that he is here today for low back, L (Left) leg and R (Right) elbow pain. Pt. states he fell 3 x (three times) this morning and that is how his R elbow was hurt. R elbow is swollen, painful, and bruised. Pt. reports that his L leg and low back has been hurting him for about 1 week. Pt. rates pain 10/10 (sic). Pt. caregiver confirms Pt.s account of events and also states she wonders if his new med (medications) Klonopin (for behaviors) is causing him dizziness or if it is from his leg/back as he is not walking normal (sic)." The Doctor's report indicated "X-ray OK (Okay)."</p> <p>-A 11/12/14 at 11:35am, indicated Client E was "walking to lunch and began to stumble trying to keep his balance after 2 times of an effort not to fall, he did.</p>			

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	<p>Falling to his right side to back side. He said his back hurt a little" and Client E was assessed by a nurse at the workshop.</p> <p>-A 11/12/14 at 9:45am, indicated Client E "fell hard on the way to break. His ambulation has been worse lately. Seems to be dragging his foot as he walks. Had good ROM (Range of Motion) of elbow. Said knee was ok, he fell on it all the time (sic). He was able to get up from floor on his own. Had on the padding of his winter coat at time of fall."</p> <p>-A 11/10/14 at 10:42am, indicated Client E fell in the hallway at workshop walking to break. Client E's "peers stated he fell and 3 nurses found [Client E] on his knees." The report indicated Client E "refused when nursing tried to look at his knees he said he was okay."</p> <p>3. On 1/12/15 at 1:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, investigations, and non reported incidents were reviewed. No BDDS reports were available for review for client A and C's incident reports for Injuries of Unknown Origin:</p> <p>-A 11/13/14 "Investigation" for client A indicated on 11/13/14 "It was noted that there was an unknown bruise found on</p>				

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	<p>the upper left arm on [client A]." A 11/2/14 at 7:00pm, "Accident/Incident" indicated an "unknown bruise found on upper left arm 11.5cm (centimeter) by 7cm." No interview was available for review of client A regarding the bruise. The investigation indicated staff recorded the bruise while assisting client A with his shower.</p> <p>-An 8/18/14 "Investigation" and an 8/16/14 "Accident/Incident" report for client C indicated on 8/16/14 at 6:05pm, "staff asked [client C] if he had any cuts or bruises we needed to know about. [Client C] said yes and showed [staff] a 3cm bruise on his upper left abdominal [client C] doesn't know when or where he got it. [Client C] says it only hurts if he touches it." The investigation did not include witness statements, who was interviewed, environmental review, or events before/after the bruise was recorded.</p> <p>On 1/13/15 at 1:00pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Vice President of Residential Services (VPRS) was conducted. The QIDP and the VPRS both indicated there were no documented BDDS reports available for review for client A and C's injuries of unknown origin. The QIDP indicated client A and</p>			

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	<p>C's injuries of unknown origin investigations were not thorough and did not document events, interviews completed, or outcomes of the investigations. The VPRS indicated the facility followed the BDDS policy and procedure for allegations of abuse, neglect, and/or mistreatment.</p> <p>Client C's record was reviewed on 1/13/15 at 10:30am. Client C's 5/1/14 ISP (Individual Support Plan) and 5/2014 BSP (Behavior Support Plan) indicated staff were to supervise client C while in the community and client C required twenty-four hour staff supervision.</p> <p>On 1/13/15 at 11:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Vice President of Residential Services (VPRS) was conducted. The VPRS indicated the agency followed the BDDS reporting policy and procedure. The QIDP and the VPRS both indicated the facility staff neglected to supervise clients A, C, and E according to their plans and identified needs. The QIDP stated "all clients" required staff to supervise them and to know where and what clients were doing. The QIDP stated client E "required staff to assist with transfers, to walk, and to smoke."</p>						

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	<p>On 1/12/15 at 1:00pm, a review was completed of the 10/2005 "Bureau of Developmental Disability Services Policy and Guidelines." The BDDS policy and procedure indicated "...Abuse, Neglect, and Mistreatment of Individuals...it is the policy of the company to ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse by anyone including but not limited to: facility staff...other individuals, or themselves." The policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual." The policy and procedure indicated "...Neglect, includes failure to provide appropriate care, food, medical care, or supervision...."</p> <p>On 1/12/15 at 1:00pm, a record review of the facility's undated policy and procedures for Abuse, Neglect, Exploitation indicated "Abuse, Neglect, Exploitation" neglect was defined as "failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide the support necessary to an individual's psychological and social well being. Failure to meet the basic need</p>						

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W000153	<p>requirements such as food, shelter, clothing and to provide a safe environment...." The policy indicated failure to implement clients' program plans could also be considered neglect. The policy indicated the facility staff should immediately report allegations of abuse, neglect, and/or mistreatment to the administrator and to BDDS in accordance with State Law.</p> <p>This federal tag relates to complaint #IN00162211.</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. Based on record review and interview, for 2 of 2 injuries of unknown source reviewed for 2 of 8 clients (clients A and C), the facility failed to report to BDDS (Bureau of Developmental Disabilities Services) in accordance with State Law.</p> <p>Findings include:</p>	W000153	<p><b>Toensure that established agency policies and procedures incident reporting areimplemented and executed as written, the following corrective action(s) will beimplemented:</b></p> <p>1) Allstaff located at 3770 North 80 West (Sycamore</p>	02/22/2015

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3770 W 80 N KOKOMO, IN 46901			
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	<p>On 1/12/15 at 1:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, investigations, and non reported incidents were reviewed. No BDDS reports were available for review of client A and C's incident reports for Injuries of Unknown Origin:</p> <p>-A 11/13/14 "Investigation" for client A indicated on 11/13/14 "It was noted that there was an unknown bruise found on the upper left arm on [client A]." A 11/2/14 at 7:00pm, "Accident/Incident" indicated an "unknown bruise found on upper left arm 11.5cm (centimeter) by 7cm." The investigation indicated staff recorded the bruise while assisting client A with his shower.</p> <p>-An 8/18/14 "Investigation" and an 8/16/14 "Accident/Incident" report for client C indicated on 8/16/14 at 6:05pm, "staff asked [client C] if he had any cuts or bruises we needed to know about. [Client C] said yes and showed [staff] a 3cm bruise on his upper left abdominal [client C] doesn't know when or where he got it. [Client C] says it only hurts if he touches it."</p> <p>On 1/13/15 at 1:00pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Vice</p>		<p>Group home) will be retrained on the agency accident/injury process and incident reporting as well as changes to the internal routing system for the above mentioned processes to ensure evaluation of all accident/injury and incident reports in a more timely manner. Record of training forms will be completed once trainings are finalized. <i>Refer to Appendix A and B for Record of Training forms to be used</i></p> <p>2) All Residential House Managers (RHM) and Qualified Intellectual Disabilities Professionals (QIDP) within the Residential Services Department will be retrained on BDDS reportable guidelines, how to file a BDDS report, and evaluations for all accident/injury reports to ensure a higher level of monitoring with all incidents. Record of training forms will be completed as all trainings are finalized.</p>				

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W000154	<p>President of Residential Services (VPRS) was conducted. The QIDP and the VPRS both indicated there were no BDDS reports available for review for client A and C's injuries of unknown origin.</p> <p>On 1/13/15 at 11:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Vice President of Residential Services (VPRS) was conducted. The VPRS indicated the agency followed the BDDS reporting policy and procedure and the unknown injuries were not reported to BDDS.</p> <p>This federal tag relates to complaint #IN00162211.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, for 2 of 2 injuries of unknown source and for 2 of 20 incidents reviewed for 3 of 8 clients (clients A, C, and E), the facility failed to document completed thorough investigations of unknown injuries and allegations of neglect for clients A, C, and E.</p>	W000154	<b>Toensure that established agency policies and procedures for investigations arebeing implemented and executed as written, the following corrective action(s)will be implemented:</b>	02/22/2015

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	<p>Findings include:</p> <p>1. On 1/12/15 at 1:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and included the following incidents for client A's AWOL (Absent Without Leave) behaviors:</p> <p>-A 1/1/15 BDDS report for an incident on 1/1/15 at 1:19pm, indicated the Residential Manager (RM) was notified by the staff "that [client A] had eloped from the group home. The [name of city] Police brought [client A] back to the group home around 1:35pm. [name of city] dispatch had received a phone call at 1:19pm, that an individual was sitting in a yard. Police arrived on the scene at 1:31pm, [client A] had informed the Police he made sure his shoes and coat was (sic) on before leaving because it was cold outside. [Client A] was down the road from his group home." The report indicated the staff were suspended on 1/1/15 after the incident was reported. The report indicated the staff were to check the door alarms every 15 minutes "to ensure they were working."</p> <p>-A 1/9/15 Follow up BDDS report indicated "APS (Adult Protective Services) substantiated neglect on the</p>		<p>1) All investigations will be conducted in the manner outlined on the Residential Services Investigation Process. <i>Refer to Appendix D for process outline.</i> To ensure that all investigations are conducted in a uniform and consistent manner, all Residential House Managers, Qualified Development Disability Professionals, Nurses, the Director, and the Residential Services Coordinator will be trained on the newly established investigation process outline. <i>Refer to Appendix E for Record of Training form to be used in documenting training.</i></p>				

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	<p>staff...The door alarms were turned off. We now have double alarms on all interior/exterior doors and have implemented every 15 minute safety checks to ensure the alarms are on and in working condition...It is believed [client A] was gone for about 1 hour 5 minutes...New goals have been implemented for teaching tools in regards to eloping without staff and the dangers, a cell phone has been purchased for him to call the Residential Manager (or other leadership agency staff) to talk instead of eloping...."</p> <p>-A 1/3/15 "Investigation" for client A's 1/1/15 incident indicated "two staff were working (at the group home) and were unaware of [client A's] whereabouts." The investigation indicated at "approximately 12:30pm, [client A] became upset when he asked a staff member if he could go outside and smoke a cigarette and they asked him to wait for a few minutes because they were in the middle of counting consumer money... [Client A] eloped from the home without staff knowledge while both staff members working were in the med (medication) room...During the time [client A] was away from the home he sat down outside in someone's yard and the individual at that residence contacted the police." The investigation indicated</p>						

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	<p>client A was gone "for approximately 1 hour, when the police brought him back to the group home...Neither staff working at the time of the elopement knew [client A] had even left until [client A] was brought home by the police."</p> <p>-A 9/11/14 BDDS report for an incident on 9/10/14 at 6:05pm, indicated "Around 6:08pm, a neighbor notified staff that [client A] was walking down the road. Staff were unaware that [client A] had left the home. They immediately began to look for him." At 6:45pm, client A was located "about a mile away from the home, sitting on the corner of 400 West and State Road 22." The report indicated client A was not injured "but wet from the rain." The report indicated client A was "upset over some food items." The report indicated client A "had an elopement plan in place and the home has window and door alarms. These alarms will be checked to ensure that they are in proper working conditions."</p> <p>-The 9/11/14 Investigation for client A's 9/10/14 incident indicated client A eloped from the group home "without staffs (sic) knowledge" after becoming "upset at staff when he was asked to clean up his dishes from dinner so he went to his room and stayed there for some time." The investigation indicated</p>			

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	<p>"the allegations of neglect are unsubstantiated. Consumer [client A] has a history of elopement on a regular basis." The investigation indicated two (2) staff were on duty with eight (8) clients in the group home.</p> <p>-GHS (Group Home Staff) #8's 9/11/14 witness statement indicated two staff were at the group home during client A's 9/10/14 elopement incident. GHS #8 stated "I think we kinda (sic) realized at the same time. I went into [client A's] bedroom...I realized [client A] wasn't in his bed. [GHS #7] came in and said some guy came and told her one of our consumers was walking down the road. By the time I got to tell [client C] that I needed to check on someone, [GHS #7] was coming in saying some guy was telling [client C]." GHS #8 stated it was "about 6:10 (no am or pm was indicated)" and GHS #7 was pulling out of the driveway in the van to go look for client A. GHS #8 indicated she called the police to report client A missing after the Group Home Manager called to tell her to call the police.</p> <p>On 1/13/15 at 1:00pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Vice President of Residential Services (VPRS) was conducted. The QIDP and the VPRS</p>			

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	<p>both indicated staff failed to supervise client A according to his identified needs. The QIDP indicated client A was not independent in the community and needed staff to supervise him while in the community. The QIDP indicated client A's Elopement plan indicated staff were to have kept client A within line of sight when he becomes upset to prevent client A's AWOL/Elopement behavior and staff did not implement client A's plans on 1/1/15 or on 9/10/14. The VPRS indicated the facility followed the BDDS policy and procedure for investigating and completing thorough investigations of allegations of abuse, neglect, and/or mistreatment. The VPRS indicated the investigation was not thorough. The VPRS indicated the investigation did not include the environmental factor of the outside temperature.</p> <p>2. On 1/12/15 at 1:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and included the following incidents of client E's AWOL (Absent Without Leave) behaviors:</p> <p>-A 1/2/15 BDDS report for an incident on 1/2/15 at 9:15am, indicated client E's "immediate Supervisor observed [client E] leaving his work area to use the restroom. She stated that he is not good</p>			

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	<p>about notifying her when he needs to leave to go to the restroom. When he did not return in what was the normal amount of time for him to be gone she informed a co worker that she had a walkie talkie and was going to go look for him. He was not in the restroom...The supervisor walked to the cafeteria to see if he was (there)...and she found him in the hallway between the cafeteria and the workshop (at the back of the building)...[Client E] stated that he went to the bathroom and then went to the back door and there was a 'big black guy that I've never seen' standing near it but that he let himself out (of the building). [Client E] said after he got done smoking he just waited until someone come by to let him in. He did not know who let him in...." The report indicated client E "was reminded that he can only go out to smoke during designated smoke breaks when staff are out there to supervise."</p> <p>On 1/12/15 at 1:35pm, a 1/2/15 "Investigation" for client E's incident was reviewed. The investigation was a one and one half page narrative from the investigator, did not include witness statements, the questions asked during the investigation, who completed the investigation, if the investigation was reviewed for administrative oversight, any documents reviewed to complete the</p>			

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	<p>investigation, corrective measures, and did not review the environmental conditions during the incident. The investigation indicated the events, that staff were suspended, "Since line of sight supervision is not required for [client E] and he is able to go to and from the restroom on his own, it is not believed that [the staff name] was neglectful in providing adequate supervision...[Client E] was also reminded that there are breaks when into his day and those are the times he should be going to have a cigarette."</p> <p>On 1/12/15 at 1:35pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) for the group home, the Vice President of Residential Services (VPRS), the Workshop Director (WD), and the Workshop Investigator (WI) was conducted. The QIDP and the VPRS both stated client E was to have "direct eye sight supervision by the facility staff when outside the group home, in the community, and while smoking." The QIDP and the VPRS both stated client E was not independent in the community for his safety, had had falls "frequently," and required the supervision of the staff while outside the workshop. The QIDP and the VPRS both indicated they did not review investigations completed at the workshop because the</p>			

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	workshop leadership was in charge to complete investigations of incidents which occurred at the workshop. The QIDP and the VPRS both stated they "did not have" the investigation for client E's AWOL at the workshop. The WD and the WI both stated "the workshop completed their own investigations" for incidents which occur at the workshop. The WD stated the regulation "does not mandate a thorough investigation, only that an investigation be completed." The WD indicated it was acceptable practice for the investigator to paraphrase what the staff and client said regarding the incident. The WD stated witness statements should be documented, the witnesses do not need to write out their own statements "It's needless paperwork, it's time consuming." The WD and WI both stated the investigator was "the only person" at the workshop who reviews her own investigations. The WD and the WI both indicated the investigation did not include witness statements, an incident report, if the investigation was reviewed for administrative oversight, any documents reviewed to complete the investigation, corrective measures, and did not review the environmental conditions during the incident. Both staff indicated the investigation did not include who the man was client E indicated he let into the back of the			

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	<p>building through the security door. The WD indicated there was a door bell at the rear of the workshop and he was unsure if the bell was operational.</p> <p>3. On 1/12/15 at 1:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, investigations, and non reported incidents were reviewed. No BDDS reports were available for review for client A and C's incident reports for Injuries of Unknown Origin:</p> <p>-A 11/13/14 "Investigation" for client A indicated on 11/13/14 "It was noted that there was an unknown bruise found on the upper left arm on [client A]." A 11/2/14 at 7:00pm, "Accident/Incident" indicated an "unknown bruise found on upper left arm 11.5cm (centimeter) by 7cm." No interview was available for review of client A regarding the bruise. The investigation indicated staff recorded the bruise while assisting client A with his shower.</p> <p>-An 8/18/14 "Investigation" and an 8/16/14 "Accident/Incident" report for client C indicated on 8/16/14 at 6:05pm, "staff asked [client C] if he had any cuts or bruises we needed to know about. [Client C] said yes and showed [staff] a 3cm bruise on his upper left abdominal</p>						

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W000157	<p>[client C] doesn't know when or where he got it. [Client C] says it only hurts if he touches it." The investigation did not include witness statements, who was interviewed, environmental review, or events before/after the bruise was recorded.</p> <p>On 1/13/15 at 1:00pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Vice President of Residential Services (VPRS) was conducted. The QIDP indicated client A and C's injuries of unknown origin investigations were not thorough and did not document events, interviews completed, or outcomes of the investigations.</p> <p>This federal tag relates to complaint #IN00162211.</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 observation, record review, and interview, for 2 of 20 reportable incidents reviewed for 2 of 8 clients (clients A and</p>	W000157	<b>Toensure effective corrective action for clients based on their individual needs,the</b>	02/22/2015

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	<p>E), the facility failed to complete effective corrective action for clients A and E to address a pattern of incidents of elopement.</p> <p>Findings include:</p> <p>1. On 1/12/15 at 1:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and included the following incidents for client A's AWOL (Absent Without Leave) behaviors:</p> <p>-A 1/1/15 BDDS report for an incident on 1/1/15 at 1:19pm, indicated the Residential Manager (RM) was notified by the staff "that [client A] had eloped from the group home. The [name of city] Police brought [client A] back to the group home around 1:35pm. [name of city] dispatch had received a phone call at 1:19pm, that an individual was sitting in a yard. Police arrived on the scene at 1:31pm, [client A] had informed the Police he made sure his shoes and coat was (sic) on before leaving because it was cold outside. [Client A] was down the road from his group home." The report indicated the staff were suspended on 1/1/15 after the incident was reported. The report indicated the staff were to check the door alarms every 15 minutes "to ensure they were working."</p>		<p><b>following corrective action(s) will be implemented:</b></p> <p>1) Diagnostic and Evaluation forms (D&amp;E's) for all clients residing at 3770 North 80 West(Sycamore group home) will be reviewed and revisions to all Behavior Support Plans (BSP) will be completed to reflect past information and present information needed for continuity of care. BSP's will continually be revised to update any new targeted behaviors, incidents, or medical issues as they arise. Direct care staff will be promptly trained on any revisions or additions to individual plans. Record of Training forms will be completed once all trainings are finalized.</p> <p>2) The agency has purchased a cellular phone for client A. The contact numbers for the agency administrative office, the Sycamore group home in which he resides, the Residential House Manager, Qualified Intellectual Disabilities Professional, and the Director of Residential Services were programmed into phone. A plan was implemented in which</p>	

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3770 W 80 N KOKOMO, IN 46901
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	<p>-A 1/9/15 Follow up BDDS report indicated "APS (Adult Protective Services) substantiated neglect on the staff...The door alarms were turned off. We now have double alarms on all interior/exterior doors and have implemented every 15 minute safety checks to ensure the alarms are on and in working condition...It is believed [client A] was gone for about 1 hour 5 minutes...New goals have been implemented for teaching tools in regards to eloping without staff and the dangers, a cell phone has been purchased for him to call the Residential Manager (or other leadership agency staff) to talk instead of eloping...."</p> <p>-A 1/3/15 "Investigation" for client A's 1/1/15 incident indicated "two staff were working (at the group home) and were unaware of [client A's] whereabouts." The investigation indicated at "approximately 12:30pm, [client A] became upset when he asked a staff member if he could go outside and smoke a cigarette and they asked him to wait for a few minutes because they were in the middle of counting consumer money... [Client A] eloped from the home without staff knowledge while both staff members working were in the med (medication) room...During the time</p>		<p>client A carries the phone with him at all times and informal goals are being implemented to show him how to correctly use his phone. The use of the phone has also been added to the Behavioral Support Plan(BSP). The phone also has "5 star" capabilities in which an emergency dispatch system is contacted when the designated button is pushed. The contact information for the Qualified Intellectual Disabilities Professional and Director of Residential Services was provided to the dispatch service as emergency contacts.</p> <p>3) Client E has been placed in a physician ordered wheel chair and requires staff supervision and assistance with all transfers. The QIDP has created and implemented a <i>Workshop Falling Plan</i>, <i>Falling Management Plan</i>, and a <i>Transferring plan</i>. All workshop staff as well as staff located at 3770 North 80 West (Sycamore group home) will be trained on all plans. Record of training forms will be completed as trainings are</p>	

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	<p>[client A] was away from the home he sat down outside in someone's yard and the individual at that residence contacted the police." The investigation indicated client A was gone "for approximately 1 hour, when the police brought him back to the group home...Neither staff working at the time of the elopement knew [client A] had even left until [client A] was brought home by the police." The investigation indicated there were two staff on duty with eight clients on 1/1/15.</p> <p>-A 9/11/14 BDDS report for an incident on 9/10/14 at 6:05pm, indicated "Around 6:08pm, a neighbor notified staff that [client A] was walking down the road. Staff were unaware that [client A] had left the home. They immediately began to look for him." At 6:45pm, client A was located "about a mile away from the home, sitting on the corner of 400 West and State Road 22." The report indicated client A was not injured "but wet from the rain." The report indicated client A was "upset over some food items." The report indicated client A "had an elopement plan in place and the home has window and door alarms. These alarms will be checked to ensure that they are in proper working conditions."</p> <p>-The 9/11/14 Investigation for client A's 9/10/14 incident indicated client A</p>		finalized.				

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	<p>eloped from the group home "without staffs (sic) knowledge" after becoming "upset at staff when he was asked to clean up his dishes from dinner so he went to his room and stayed there for some time." The investigation indicated "the allegations of neglect are unsubstantiated. Consumer [client A] has a history of elopement on a regular basis." The investigation indicated two (2) staff were on duty with eight (8) clients in the group home.</p> <p>-GHS (Group Home Staff) #8's 9/11/14 witness statement indicated two staff were at the group home during client A's 9/10/14 elopement incident. GHS #8 stated "I think we kinda (sic) realized at the same time. I went into [client A's] bedroom...I realized [client A] wasn't in his bed. [GHS #7] came in and said some guy came and told her one of our consumers was walking down the road. By the time I got to tell [client C] that I needed to check on someone, [GHS #7] was coming in saying some guy was telling [client C]." GHS #8 stated it was "about 6:10 (no am or pm was indicated)" and GHS #7 was pulling out of the driveway in the van to go look for client A. GHS #8 indicated she called the police to report client A missing after the Group Home Manager called to tell her to call the police.</p>						

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	<p>Client A's record was reviewed on 1/12/15 at 7:30pm and on 1/13/15 at 10:45am. Client A's 5/1/14 ISP (Individual Support Plan) and 5/2014 BSP (Behavior Support Plan) both indicated client A had targeted behaviors of Elopement. Client A's plans indicated staff were to provide twenty-four hour supervision. Client A's diagnoses included, but were not limited to: Major Depression, Seizure Disorder, Cerebral Palsy, and Pain Disorder. Client A's 5/1/14 "Elopement Plan" indicated when client A elopes "it is because he is upset...staff will be aware of this and keep [client A] within line of sight at all times...[client A] requires 24 hour awake staff, and must remain within line of sight any time that he is in the community...." Client A's Elopement Plan indicated he was at risk for falls, seizures, and for his safety. Client A's 5/1/14 "Capacity for Independence/Informed Consent" assessment indicated client A does not recognize danger when upset and required supervision in the community. Client A was not independent with money or medications, and did not have independent pedestrian safety skills. Client A's assessment indicated the agency staff assist client A to make decisions of informed consent.</p>			
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	<p>On 1/13/15 at 1:00pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Vice President of Residential Services (VPRS) was conducted. The QIDP and the VPRS both indicated staff failed to supervise client A according to his identified needs. The QIDP indicated client A was not independent in the community and needed staff to supervise him while in the community. The QIDP indicated client A's Elopement plan indicated staff were to have kept client A within line of sight when he becomes upset to prevent client A's AWOL/Elopement behavior and staff did not implement client A's plans on 1/1/15 or on 9/10/14. The QIDP indicated client A's plan was reviewed and no changes were implemented as the result of the meeting. The QIDP indicated there was not documented evidence to ensure the staff were retrained for client A's plans. The VPRS indicated neglect was the failure to provide sufficient staff supervision based on identified behaviors. The VPRS indicated staff were retrained after each AWOL on client A's plans and client A continued to leave the facility without staffs knowledge which required police interventions. The VPRS indicated the corrective measures taken after client A's 9/2014 AWOL behavior were not</p>			
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	<p>effective to prevent client A from further AWOL.</p> <p>On 1/12/15 from 4:00pm until 5:45pm, client A was observed at the group home and did not have an operational cell phone. At 4:15pm, client A indicated he left the group home without staff on 1/1/15 after he became upset with a staff. Client A indicated he did not have a cell phone for his use.</p> <p>2. On 1/12/15 at 1:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and included the following incidents of client E's AWOL (Absent Without Leave) behaviors:</p> <p>-A 1/2/15 BDDS report for an incident on 1/2/15 at 9:15am, indicated client E's "immediate Supervisor observed [client E] leaving his work area to use the restroom. She stated that he is not good about notifying her when he needs to leave to go to the restroom. When he did not return in what was the normal amount of time for him to be gone she informed a co worker that she had a walkie talkie and was going to go look for him. He was not in the restroom...The supervisor walked to the cafeteria to see if he was (there)...and she found him in the hallway between the cafeteria and the workshop</p>			

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	<p>(at the back of the building)...[Client E] stated that he went to the bathroom and then went to the back door and there was a 'big black guy that I've never seen' standing near it but that he let himself out (of the building). [Client E] said after he got done smoking he just waited until someone come by to let him in. He did not know who let him in...." The report indicated client E "was reminded that he can only go out to smoke during designated smoke breaks when staff are out there to supervise."</p> <p>On 1/12/15 at 1:35pm, a 1/2/15 "Investigation" for client E's incident was reviewed. The investigation was a one and one half page narrative from the investigator, did not include witness statements, the questions asked during the investigation, who completed the investigation, if the investigation was reviewed for administrative oversight, any documents reviewed to complete the investigation, corrective measures, and did not review the environmental conditions during the incident. The investigation indicated the events, that staff were suspended, "Since line of sight supervision is not required for [client E] and he is able to go to and from the restroom on his own, it is not believed that [the staff name] was neglectful in providing adequate supervision....[Client</p>						

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	<p>E] was also reminded that there are breaks when into his day and those are the times he should be going to have a cigarette."</p> <p>On 1/12/15 at 1:35pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) for the group home, the Vice President of Residential Services (VPRS), the Workshop Director (WD), and the Workshop Investigator (WI) was conducted. The QIDP and the VPRS both stated client E was to have "direct eye sight supervision by the facility staff when outside the group home, in the community, and while smoking." The QIDP and the VPRS both stated client E was not independent in the community for his safety, had had falls "frequently," and required the supervision of the staff while outside the workshop. The QIDP and the VPRS both indicated they did not review investigations completed at the workshop because the workshop leadership was in charge to complete investigations of incidents which occurred at the workshop. The QIDP and the VPRS both stated they "did not have" the investigation for client E's AWOL at the workshop. The WD indicated there was a door bell at the rear of the workshop and he was unsure if the bell was operational. The WI indicated she did not review client E's Behavior</p>			
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	<p>Plan or Individual Support Plan to ensure what level of supervision he required. The WD and WI both indicated staff were not retrained after client E's incident, the environment was not checked, the investigative techniques were not reviewed, and no documented corrective measures were employed.</p> <p>Client E's record was reviewed on 1/13/15 at 9:00am. Client E's 9/26/14 ISP (Individual Support Plan) and 9/2014 BSP (Behavior Support Plan) indicated Client E required twenty-four hour staff supervision. Client E's diagnoses included, but were not limited to: Schizophrenia, Intermittent Explosive Disorder, Oppositional Defiant Disorder, ADHD (Attention Deficient Hyperactivity Disorder), and Severe Communication Disorder with Apraxia. Client E's 12/10/14 "Hydrocephalus Plan" indicated Hydrocephalus is an atrophy of fluid around the brain. "Hydrocephalus is the abnormal accumulation of cerebrospinal fluid, usually under increased pressure in the skull, in ventricles of the brain. Symptoms of Hydrocephalus can include: short term memory loss, motion and visual difficulties, shuffling of the feet, difficulty walking, coordination difficulties, slower than normal movements, and poor balance." Client</p>						

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	<p>E's 12/3/14 "Falling Management Plan" indicated Client E had a "current history of falling" and a "traumatic brain injury" 20 years ago from a car accident. Client E's Hydrocephalus Plan and Fall Plan both indicated staff were to help Client E identify situations and hazards that can cause accidents to increase Client E's awareness of potential for falls and staff were to assist Client E while walking if unsteady and be "aware" when Client E was walking.</p> <p>During observations on 1/12/15 from 4:00pm until 5:45pm, Client E was observed at the group home. At 5:30pm, client E indicated he recalled the incident at the workshop. Client E indicated he wanted a cigarette, went outside the workshop, and the security door locked behind him. Client E stated he "beat on the door with his fist awhile and finally someone came (to the door) after 20-25 minutes." Client E indicated it was cold outside. From 5:00pm until 5:10pm, client E was outside alone smoking without facility staff. From 5:30pm until 5:45pm, client E was outside alone smoking without facility staff.</p> <p>This federal tag relates to complaint #IN00162211.</p> <p>9-3-2(a)</p>						

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W000189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on record review and interview, the facility failed to provide sufficient training and/or retraining to ensure staff provided staff supervision and implementation of client A's BSP (Behavior Support Plan) and ISP (Individual Support Plan).</p> <p>Findings include:</p> <p>On 1/12/15 at 1:30pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and included the following incidents for client A's AWOL (Absent Without Leave) behaviors:</p> <p>-A 1/1/15 BDDS report for an incident on 1/1/15 at 1:19pm, indicated the Residential Manager (RM) was notified by the staff "that [client A] had eloped from the group home. The [name of city] Police brought [client A] back to the group home around 1:35pm. [name of</p>	W000189	<p><b>Toensure effective corrective action for clients based on their individual needs,the following corrective action(s) will be implemented:</b></p> <p>1) Theagency has purchased a cellular phone for client A. The contact numbers for theagency administrative office, the Sycamore group home in which he resides, theResidential House Manager, Qualified Intellectual Disabilities Professional,and the Director of Residential Services were programmed into phone. A plan wasimplemented in which client A carries the phone with him at all times andinformal goals are being implemented to show him how to correctly use hisphone. The use of the phone has also been added to</p>	02/22/2015
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	<p>city] dispatch had received a phone call at 1:19pm, that an individual was sitting in a yard. Police arrived on the scene at 1:31pm, [client A] had informed the Police he made sure his shoes and coat was (sic) on before leaving because it was cold outside. [Client A] was down the road from his group home." The report indicated the staff were suspended on 1/1/15 after the incident was reported. The report indicated the staff were to check the door alarms every 15 minutes "to ensure they were working."</p> <p>-A 1/9/15 Follow up BDDS report indicated "APS (Adult Protective Services) substantiated neglect on the staff...The door alarms were turned off. We now have double alarms on all interior/exterior doors and have implemented every 15 minute safety checks to ensure the alarms are on and in working condition...It is believed [client A] was gone for about 1 hour 5 minutes...New goals have been implemented for teaching tools in regards to eloping without staff and the dangers, a cell phone has been purchased for him to call the Residential Manager (or other leadership agency staff) to talk instead of eloping...."</p> <p>-A 1/3/15 "Investigation" for client A's 1/1/15 incident indicated "two staff were</p>		<p>the Behavioral Support Plan(BSP). The phone also has "5 star" capabilities in which an emergency dispatchsystem is contacted when the designated button is pushed. The contactinformation for the Qualified Intellectual Disabilities Professional andDirector of Residential Services was provided to the dispatch service asemergency contacts.</p>		

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	<p>working (at the group home) and were unaware of [client A's] whereabouts." The investigation indicated at "approximately 12:30pm, [client A] became upset when he asked a staff member if he could go outside and smoke a cigarette and they asked him to wait for a few minutes because they were in the middle of counting consumer money... [Client A] eloped from the home without staff knowledge while both staff members working were in the med (medication) room...During the time [client A] was away from the home he sat down outside in someone's yard and the individual at that residence contacted the police." The investigation indicated client A was gone "for approximately 1 hour, when the police brought him back to the group home...Neither staff working at the time of the elopement knew [client A] had even left until [client A] was brought home by the police."</p> <p>-A 9/11/14 BDDS report for an incident on 9/10/14 at 6:05pm, indicated "Around 6:08pm, a neighbor notified staff that [client A] was walking down the road. Staff were unaware that [client A] had left the home. They immediately began to look for him." At 6:45pm, client A was located "about a mile away from the home, sitting on the corner of 400 West and State Road 22." The report indicated</p>			

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	<p>client A was not injured "but wet from the rain." The report indicated client A was "upset over some food items." The report indicated client A "had an elopement plan in place and the home has window and door alarms. These alarms will be checked to ensure that they are in proper working conditions."</p> <p>-The 9/11/14 Investigation for client A's 9/10/14 incident indicated client A eloped from the group home "without staffs (sic) knowledge" after becoming "upset at staff when he was asked to clean up his dishes from dinner so he went to his room and stayed there for some time." The investigation indicated "the allegations of neglect are unsubstantiated. Consumer [client A] has a history of elopement on a regular basis." The investigation indicated two (2) staff were on duty with eight (8) clients in the group home.</p> <p>-GHS (Group Home Staff) #8's 9/11/14 witness statement indicated two staff were at the group home during client A's 9/10/14 elopement incident. GHS #8 stated "I think we kinda (sic) realized at the same time. I went into [client A's] bedroom...I realized [client A] wasn't in his bed. [GHS #7] came in and said some guy came and told her one of our consumers was walking down the road.</p>						

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NAME OF PROVIDER OR SUPPLIER  BONA VISTA PROGRAMS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3770 W 80 N KOKOMO, IN 46901
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	<p>By the time I got to tell [client C] that I needed to check on someone, [GHS #7] was coming in saying some guy was telling [client C]." GHS #8 stated it was "about 6:10 (no am or pm was indicated)" and GHS #7 was pulling out of the driveway in the van to go look for client A. GHS #8 indicated she called the police to report client A missing after the Group Home Manager called to tell her to call the police.</p> <p>Client A's record was reviewed on 1/12/15 at 7:30pm and on 1/13/15 at 10:45am. Client A's 5/1/14 ISP (Individual Support Plan) and 5/2014 BSP (Behavior Support Plan) both indicated client A had targeted behaviors of Elopement. Client A's plans indicated staff were to provide twenty-four hour supervision. Client A's diagnoses included, but were not limited to: Major Depression, Seizure Disorder, Cerebral Palsy, and Pain Disorder. Client A's 5/1/14 "Elopement Plan" indicated when client A elopes "it is because he is upset...staff will be aware of this and keep [client A] within line of sight at all times...[client A] requires 24 hour awake staff, and must remain within line of sight any time that he is in the community...." Client A's Elopement Plan indicated he was at risk for falls, seizures, and for his safety. Client A's</p>			

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	<p>5/1/14 "Capacity for Independence/Informed Consent" assessment indicated client A does not recognize danger when upset and required supervision in the community. Client A was not independent with money or medications, and did not have independent pedestrian safety skills. Client A's assessment indicated the agency staff assist client A to make decisions of informed consent.</p> <p>On 1/13/15 at 1:00pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the Vice President of Residential Services (VPRS) was conducted. The QIDP and the VPRS both indicated staff neglected to supervise client A according to his identified needs. The QIDP indicated client A was not independent in the community and needed staff to supervise him while in the community. The QIDP indicated client A's Elopement plan indicated staff were to have kept client A within line of sight when he becomes upset to prevent client A's AWOL/Elopement behavior and staff did not implement client A's plans on 1/1/15 or on 9/10/14. The VPRS indicated the staff failed to supervise client A according to his identified needs.</p> <p>This federal tag relates to complaint</p>						

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