STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G802	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BONA VISTA PROGRAMS INC	112 E WESTMORELAND KOKOMO, IN 46901

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W 0000 Bldg. 00	This visit was for the investigation of complaint #IN00180355. Complaint #IN00180355: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W149, W154, W157, W227, W240 and W252. Survey dates: 10/19, 10/20 and 10/30/15. Facility Number: 012527 Provider Number: 15G802 AIM Number: 201024860 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 11/6/15.	W 0000		
W 0149 Bldg. 00	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, interview and record review for 2 of 4 sampled clients (A and C), the facility failed to implement its written policy and procedures to prevent neglect of a client in regard to the client's elopement behavior.	W 0149	**Finding(s)** **1. "*The facilitiesinvestigations were not completed thoroughly and investigated appropriately. Thefacility failed to clearly indicate/explain situations that***	11/29/2015

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

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

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	Findings include: The facility's reportable incident reports and/or investigations were reviewed on 10/19/15 at 2:45 PM. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive): -"[Client C] walked out the door at the group home on 7/4/15 at 7pm. The door alarm alerted staff and they followed him outside toward the gate. [Client A] also saw [client C] walking toward the gate and pulled his arm, causing [client C] to fall onto his backside. [Client A] continued to pull [client C] back on the sidewalk, causing a 3inch (sic) by 3 inch abrasion on his backside. Staff redirected [client A] to let go and provided basic first aid to [client C]. Staff gently cleaned the abrasion with soap and water, then applied antibiotic ointment and a bandage over the area. Staff completed an accident incident report and contacted On-Call and the Residential Nurse... [Client C] has a BSP (Behavior Support Plan) that addresses elopement. The group home is equipped with HRC (Human Rights Committee) approved window and door alarms. [Client A] has a BSP that includes physical aggression and attempting to interfere with other		***had occurred, wasnot all inclusive to information that was required, and failed to indicate/includeany recommendations and/or corrective actions in regards to this incident."*** **CorrectiveAction(s):** **Toensure all policies and procedures for all investigations include allinformation that is required at the State and Federal level and that allallegations or incidents of abuse, neglect, exploitation, and mistreatment arethoroughly investigated and include all imperative information required:** 1.Allallegations or incidents of abuse, neglect, exploitation, mistreatment, will bethoroughly investigated by the Social Service Coordinator. 2.TheResidential Director of Quality Assurance and Social Services will besupervising the Social Service Coordinator to provide administrative oversighton all investigations. He will ensure that all allegations are thoroughly beinginvestigated as per State and Federal guidelines, as well ensure that eachinvestigation indicates/recommends a corrective action. 3.TheDirector of Quality Assurance and Social Services and the Executive Vicepresident will be reviewing all investigations to ensure the investigations	

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	consumers during behaviors. [Client C] has a falling risk plan in place due to his poor balance. All staff are trained on BSPs, Risk Plans, and First Aid before working with Consumers." The facility's 7/14/15 Investigation of Peer to Peer Aggression indicated "[Client A] stated that consumer [client C] had tried to leave the group home. He stated that there were no staff because one of the staff was passing medications, and the other staff was watching all of the other consumers. He stated that he then grabbed [client C] and took him back behind the gate. He stated that when he was bringing [client C] back behind the gate he (client C) dropped to the ground and got a scratch on his bottom. He stated that once he got [client C] back behind the gate, he shut and locked the gate." The facility's 7/14/15 peer to peer investigation indicated client C indicated "Consumer [client C] stated that he did not try to get out the door of the home by himself. He stated that [client A] grabbed him by the arm and drug (sic) him back to the home. He stated that he got hurt when [client A] drug (sic) him back to the home. He stated that the staff that was working at the time of the incident helped him."		arecompleted thoroughly and all policies and procedures for completinginvestigations are being followed and all State and Federal regulations arebeing met. ***1.“Thefacility failed to implement its written policy and procedures to preventneglect of client C in regards to the client’s elopement behavior.”*** - - - - **CorrectiveAction(s): Todevelop, implement, and follow all policies and procedures that prohibit abuse,neglect, exploitation, and mistreatment:** 1.TheQualified Intellectual Disabilities Professional (QIDP) will revise the BehaviorSupport Plan (BSP) to include a Behavior tracking data sheet to track theelopement incident, what route the elopement occurred, how long, and wherestaff was during the incident. The BSP will also have a stop light chart addedfor assistance with staff monitoring in regards to what level client C is onred-high alert, yellow-cautions, green- safe; Elopement Risk Plan, andIndividual Support Plan to include incident of elopement and protocol to followto prevent elopement. The QIDP will add informal program goals to addressclient C’s elopement and	

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	The facility's 7/14/15 investigation of the client to client aggression incident indicated there were 2 staff working at the group home at the time of the incident. The facility's investigation indicated one staff (staff #2) was passing medications and the other staff (staff #3) ran out behind client C when he left the group home, but client A was able to get to client C first. The facility's investigation indicated staff #3 was interviewed on 7/14/15. Staff #3's 7/14/15 witness statement indicated "1.) What happened between [client C] and [client A] the other day? [Client C] ran out of the house. I ran after him but [client A] grabbed him before I could get to him. I told [client A] to let go of him. Before [client A] let go of him [client C] fell to the ground. [Client A] then drug (sic) him back behind the gat (sic). 2.) Why did [client A] drag [client C] back to the home? He said he was just trying to help us. 3.) What did you do when the incident occurred? I helped [client C] back up. Then talked to [client A] about letting staff do their job." Staff #2's 7/8/15 witness statement indicated "1.) What happened between [client C] and [client A] the other day? "[Client C] ran out. [Staff #3] was running after him. [Client A] got to him		Pedestrian safety skills. QIDP will implementincentive plans based around the targeted behavior of elopement to encourageredirection and to assist in preventing incidents of elopement. The QIDP willtrain all staff working in the home on all revisions and additions of plans. Recordsof trainings will be completed following trainings and submitted to theResidential Director for administrative oversight (Appendix A) 2.TheResidential House Manager will retrain all staff working in the home on BonaVista's Policy for abuse, neglect, exploitation, and mistreatment. Records oftraining will be completed following trainings and submitted to the ResidentialDirector for administrative oversight (Appendix B). The Residential HouseManager and the Residential Lead DSP will check on the door/window alarms dailyto ensure they are in working 1.sheetto track the elopement incident, what route the elopement occurred, how long,and where staff was during the incident. The BSP will also have a stop lightchart added for assistance with staff monitoring in regards to what levelclient C is on red-high alert, yellow-cautions, green- safe; Elopement RiskPlan, and Individual Support Plan to include incident of elopement and protocolto follow to prevent	

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	first and grabbed his arm to pull him back to the house. [Client C] dropped to the ground. [Client A] continued to drag [client C] towards the house. 2.) Why did [client A] drag [client C] back to the home? Just go bring him back to the house. 3.) What did you do when the incident occurred? I stopped passing medications and went outside. We then brought [client C] back into the house." The facility's 7/14/15 investigation indicated "It was determined through a thorough investigation that this was a simple peer to peer aggression due to consumer [client A] responding to consumer [client C] in a negative manner. [Client A] grabbed [client C] by the arm and drug (sic) him back towards the home to keep him from running down the road. Staff were following [client C], and informed [client A] to let go of [client C]. Staff immediately separated the two consumers from one another." The facility's 7/14/15 investigation indicated the facility failed to conduct an investigation in regard to neglect due to the client's 7/4/15 elopement incident as client A indicated staff were not around when client C eloped from the group home. The facility's investigation failed to specifically indicate where staff #2 and staff #3 were located in the group home when client C eloped from the group home. The facility's investigation failed		elopement. The QIDP will add informal program goals toaddress client C's elopement and Pedestrian safety skills. QIDP will implementincentive plans based around the targeted behavior of elopement to encourageredirection and to assist in preventing incidents of elopement. The QIDP willtrain all staff working in the home on all revisions and additions of plans. Recordsof trainings will be completed following trainings and submitted to theResidential Director for administrative oversight (Appendix A) 2.TheResidential House Manager will retrain all staff working in the home on BonaVista's Policy for abuse, neglect, exploitation, and mistreatment. Records oftraining will be completed following trainings and submitted to the ResidentialDirector for administrative oversight (Appendix B). 3.TheResidential House Manager and the Residential Lead DSP will check on thedoor/window alarms daily to ensure they are in working condition. TheResidential House Manager will designate one staff per shift to check thedoor/window alarms when they arrive and when they leave shift to ensure thatthe alarms are in good working condition. This will be documented on a safetycheck sheet	

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	to include any additional client interviews in regard to the 7/4/15 incident. The facility's investigation failed to clearly indicate/explain how/why client A was able to get to client C before staff were able to get to the client. The facility's investigation failed to indicate/include any recommendations and/or corrective actions in regard to the 7/4/15 incident. -8/11/15 "On 8/11/2015 at 4:20pm Residential house manager (staff #1) received a phone call from the Residential Group Home Nurse that [client C] had eloped from the group home and was on the corner of [name of street] and [name of street] without staff. The Residential House Nurse stopped and got [client C] into her personal vehicle and took him for a drive. Residential House Manager informed the Residential Director at 4:29pm. Residential Director immediately suspended the direct support professionals on shift at the time of the elopement incident, pending investigation. [Client C] has no injuries or mental trauma due to this incident. Initial findings is (sic) that [client C] was out of the home for no more than 3-5 minutes. [Client C] has a BSP that addresses targeted behaviors including elopement and elopement risk plan.		4.TheResidential House Manager will complete a safety check list every Monday toensure that the Group Home door/window alarms are working properly and loudenough for staff to hear them. If the alarms are not working properly in thehome the Residential House Manager will contact Maintenance immediately to getthe alarm fixed. The Residential House manager will turn in a safety reportevery Monday to the Residential Directors, Executive Vice President, and theDirector of Maintenance for additional administrative oversight (Appendix C). 5.TheResidential House Manager will retrain all staff working in the home on thedoor/window alarms and the procedure to follow if they are not working or notloud enough to hear. Records of training will be completed following trainingsand submitted to the Residential Director for administrative oversight (AppendixD) 6.TheResidential House Manager and the Residential Lead DSP will review allmonitoring, tracking sheets, and documentation weekly in regards to elopementbehaviors. The Residential House Manager and Residential Lead DSP will fax allelopement tracking data to the QIDP biweekly to review unless there is anincident of elopement then the QIDP will be contacted	

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	[Client C] has a BSP and an elopement plan put in place and all direct Support (sic) professionals have been trained on it prior to working with him. The group home currently has door alarms which are HRC approved. Initial findings were the door alarms were not working at the time of this incident. Direct Support professionals (sic) on shift at time of incident will remain suspended pending outcome of investigation. [Client C] has been counseled as per the dangers in him sneaking out of the home without telling staff." The facility's 8/18/15 investigation indicated there were 4 staff working at the time of the incident and "The two staff (staff #4 and #5) that were sitting in the living room at the time [client C] eloped from the home were immediately suspended, pending an investigation. The facility's investigation indicated all 8 clients were present at the group home at the time of the incident. The facility's investigation indicated several group home clients had indicated client C left the group home on 8/11/15. Client G's 8/12/15 witness statement indicated "...He (client C) ran out. 6.) What were staff doing when [client C] ran out? In the office. I don't know. 7.) Where were you when [client C] ran out?		immediately. An Inter-disciplinaryTeam (IDT) meeting will be held to discuss the elopement and to create apreventive plan. All staff working in the home will be trained on all revisedplans. Records of training will be completed following trainings and submittedto the Residential Director for administrative oversight (Appendix F).	

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	In my room...." Client C's 8/12/15 witness statement indicated "...I sneak out the back door. 5.) Were the alarms on and working? Not go off. 6.) Did staff see? Just [staff #6]...." Client E's 8/12/15 witness statement indicated the alarms were not working at the group home. Client D's 8/12/15 witness statement indicated "1.) What did you do when you got home from workshop last night? I was sitting in the chair and then my friend came over. [Staff #4] was sitting (on) the couch. We didn't hear the bell go off. 2.) Who all was sitting in the living room? Me, [client A], [staff #4] and [staff #5]. 3.) Were there any behaviors? Except for [client C] eloping. 4.) What were [staff #4] and [staff #5] doing? Watching T.V. [staff #6] was passing medications. [Staff #1] was working on her papers in the office." Client B's 8/12/15 witness statement indicated client C had run away and staff #4 went after the client (first incident of elopement). The witness statement indicated the neighbors called the police, and the door alarms did not work until the new door alarms were delivered and			

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	placed on the doors on 8/11/15 (after the incident). RN #1's 8/12/15 witness statement indicated she found client C "sitting 'indian style' on the sidewalk." The witness statement indicated she stopped and asked client C to come with her. The witness statement indicated she went to the group home and told a staff person who was standing in the driveway she was going to take client C for a ride and to get the client something to drink. RN #1's witness statement indicated she immediately called staff #1 when she saw client C sitting on the sidewalk without staff. RN #1's 8/12/15 witness statement indicated "...As I was driving, I asked [client C] if he was upset. He stated that he had a bad day at work and tried to run off at work and fell down at work. I then asked if he had gotten hurt when he fell down at work. He showed me his right knee that had a band aid on it. I then asked [client C] if it was a good idea to run off when he was upset. He said no, but at least I wasn't in the road. The residential director then contacted me (RN #1) via phone. She asked if the alarms were on in the group home when [client C] was found. I replied that I did not know because [client C] and I went to get a drink and had not yet returned to the group home. She asked me to ask [client			

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	C] if he told anyone he was leaving. [Client C] replied no. She then asked me to ask [client C] if the door alarms went off when he left the house. [Client C] replied no...." Staff #5's 8/12/15 witness statement indicated staff #5 came into work at 4:00 PM on 8/11/15. The staff's witness statement indicated the back door was open when she came into work and she closed the back door. The witness statement indicated the alarms on the door did not go off. The staff's witness statement indicated client C eloped from the group home and went out the back door. Staff #5's 8/12/15 witness statement indicated "...I said [client C] is eloping. I followed him to the corner. [Staff #3] brought his pictures to the corner. Total was about 20 minutes. This happened shortly after 4pm. We all came back to the house, and I went downstairs to the restroom. When I came up he was gone. [Staff #4] was on the couch with all of the consumers from earlier on the couch. [Client E] was in his room. This was about 4:30ish. The alarms do not go off the way they are supposed to. I think [client C] went out when [staff #3] left. [Client C] has problems getting out of the gate. The alarm system never works right. 9.) How long was [client C] gone for? 5 minutes			

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	at the most." Staff #1's 8/12/15 witness statement indicated she and staff #6 were in the office, staff #5 was in the kitchen and staff #4 was in the living room with some clients. Staff #1's witness statement indicated "...Was the door open or closed? It was shut. But [staff #4] went outside to smoke with [client F]. The alarm was not working. Maintenance came back to fix the alarm...." Staff #6's 8/12/15 witness statement indicated he was in the office when RN #1 called to say client C was on a street corner. Staff #6 indicated the alarm had not been on and the door was closed when the clients came home. Staff #6's 8/12/15 witness statement indicated "...Did you find the alarm unplugged? Yes. [Staff #1] and I started messing with the alarm after [client C] eloped. I found it unplugged. We had to reset the alarm. 12.) Have you ever seen the alarm unplugged before? No. I don't mess with them. It's not mine to mess with." Staff #3's 8/12/15 witness statement indicated client C got upset when he came home because he couldn't find his pictures. The witness statement indicated "...I grabbed his hands and talked to him.			

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	He went outside and me and [staff #5] ran outside with him. [Client E] was standing by the van so I talked to him. [Staff #6] came out and talked to me. I went in the office and left. I sat out in my care (sic) on the phone until about 4:15pm...." Staff #3's witness statement indicated client C was in the house when he was sitting in his car on the phone. The staff indicated the alarm was not on the door at the group home. The facility's investigation indicated client C had attempted to elope prior to the second elopement when the client left the group home. The 8/18/15 investigation indicated the alarms were not working on the back door but were fixed after the second elopement incident occurred. The 8/18/15 investigation did not specifically indicate the facility substantiated neglect. The facility's investigation indicated "...Partially supports event as described/alleged...." The facility's investigation failed to indicate why the alarms had been turned off at the group home, who turned the alarms off, and/or failed to indicate/include any recommendations and/or corrective actions in regard to the 8/11/15 elopement incident. The facility's 8/20/15 Record Of Training Session was reviewed on 10/20/15 at 2:35 PM. The facility's training record			

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	indicated facility staff were trained on "Door Alarms" on 8/20/15 by staff #1. During the 10/19/15 observation period between 5:25 PM and 7:15 PM, at the group home, client E answered the door. An alarm was heard on the back door. The door alarm was low in volume. The TV was on in the living room, staff and clients were in the kitchen and in their bedrooms. The front door was opened and the 2 alarms were on the front door and both alarms sounded in a loud tone which could be heard. The living room was not in sight of the back and/or front door of the group home. The facility's office was located in the hallway (first door to the left). The front and/or back doors could not be seen from the office area. At 5:54 PM, staff #7 tested the door alarms to see if they could be heard in the living room area, in the office and/or at the back of the house. The back door alarm could barely be heard in the office area, living room area and/or at the back of the house. Interview with staff #7 on 10/19/15 at 6:15 PM when asked why the sound of the alarm was low, staff #7 stated "We have heard it for so long, we can just hear it. May need new batteries." Staff #7 indicated the back door alarm was not as loud as the front door alarm.			

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	15G802		10/30/2015

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	Client C's record was reviewed on 10/20/15 at 11:33 AM. Client C's Behavior Problem Records (BPRs) indicated when client C demonstrated "Runs/Wanders Off," staff were to mark an "O." Client C's BPRs indicated the following (not all inclusive): -January 2015 Zero incidents of "Runs/Wanders Off." -February 2015 Zero incidents of "Run/Wanders Off." -March 2015 Client C "Ran/Wander Off" at 5:00 PM, 6:00 PM and 7:00 PM. On 3/16/15 client C wandered off at 6:00 PM. Client C demonstrated the behavior a total of 4 times in March. No additional documentation and/or notations were made in regard to the incidents. -April 2015 Client C wandered off at 8:00 PM on 4/5/15 and at 4:00 PM on 4/21/15. No additional documentation and/or notations were made in regard to the incidents. -May 2015 Client C wandered off at 5:00 PM on 5/11/15. Client C also wandered off on 5/18/15 at 4:00 PM, 5:00 PM and 6:00 PM. No additional documentation and/or notations were			

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	made in regard to the incidents. -June 2015 Client C wandered off on 6/23/15 at 4:00 PM and on 6/30/15 at 6:00 PM. No additional documentation and/or notations were made in regard to the incidents. -July 2015 Client C wandered off on 7/4/15 at 2:00 PM and at 7:00 PM. Client C wandered off on 7/18/15 at 4:00 PM, 5:00 PM, 6:00 PM and at 7:00 PM. Client C wandered off on 7/20/15 at 5:00 PM, 6:00 PM and at 7:00 PM. Client C wandered off on 7/23/15 at 6:00 PM. Client C wandered off on 7/25/15 at 9:00 AM, 6:00 PM and 8:00 PM. Client C wandered off on 7/26/15 at 10:00 AM, 11:00 AM, 12 noon, 3:00 PM, 4:00 PM, 5:00 PM, 6:00 PM and 7:00 PM. The July 2015 BPR indicated client C also wandered off on 7/27/15 at 9:00 PM. Client C wandered off for a total of 28 times in July 2015. No additional documentation and/or notations were made in regard to the incidents. -August 2015 Client C wandered off on 8/9/15 at 5:00 PM and 6:00 PM. Client C wandered off on 8/10/15 at 4:00 PM, on 8/20/15 at 5:00 PM and 6:00 PM. Client C wandered off on 8/30/15 at 11:00 AM, 12 noon, 2:00 PM and 4:00 PM. The facility did not document client			

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	C's elopement from the group home on 8/11/15 (allegedly 2 incidents at the group home and 1 incident at the workshop). Client C eloped for a total of 12 times. No additional documentation and/or notations were made in regard to the incidents. -September 2015 Client C wandered off on 9/1/15 at 8:00 AM. Client C wandered off on 9/9/15 at 5:00 PM, 6:00 PM and 7:00 PM. Client C wandered off on 9/13/15 at 6:00 PM and 7:00 PM. Client C wandered off on 9/23/15 at 4:00 PM. Client C wandered off for a total of 6 times in September 2015. No additional documentation and/or notations were made in regard to the incidents. Client C's 8/15 Social Progress Notes (nurse notes) indicated the facility's nurse did not document in information about the 8/11/15 elopement incident. Client C's 7/18/14 Risk Management Assessment Plan (RMAP) indicated "... [Client C] has a history of elopement from the group home and workshop. [Client C] during times of aggression has a history of eloping from staff's presence...[Client C] has a history of going out on sidewalks in warm weather and throwing rocks at cars, strip his			

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	clothes off, and make threats at individuals passing by. [Client C] has a past history of elopement as well...[Client C] does not display safe pedestrian skills. He has run into oncoming traffic and lied down on the road. He does not understand basic safety signs and does not look before crossing streets or entering intersections...When [client C] is out of line of sight his safety is compromised due to not displaying safe pedestrian skills. Staff will document any unsafe activity in their daily notes...." Client C's 7/16/15 Elopement Risk Plan indicated "...At the group home, [client C] likes to run out the gate, and go to the corner of the street to watch the cars go by. At the workshop, he often will sit right outside or will run to the road. [Client C] would not always know how to get back home if he were to elope...Due to [client C's] risk for elopement, [client C] requires 24 hour supervision by awake staff. Direct Support Professionals should know where [client C] is at all times while inside the group home and workshop. [Client C] should remain within arm's reach of Direct Support Professionals at all times while in the community...In the event that [client C] elopes and is out of sight of Direct Support Professionals, 911 will be called immediately, them			

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	QIDP (Qualified Intellectual Disabilities Professional)...." Client C's risk plan indicated client C was to be "within line of sight" when the client was at the workshop. Client C's risk plan indicated "...Staff will be aware of his location at all times while at the group home, workshop, and community...." Client C's risk plan indicated the following in regard to when the client eloped: "When [client C] attempts to elope, staff will stand between him and the exit in a non-threatening manner and redirect him to another activity. If staff are behind him, they will follow him, keeping him within line of sight. Many times he elopes because he feels he is not receiving the attention he wants...If [client C] elopes outside or in the community and is a danger to himself or others, staff may utilize need to utilize the CPI (Crisis Prevention Intervention-restraint technique) team transport position as a last resort to redirect him to a safe place. When [client C] elopes, it is generally best if only one individual redirects him at a time. Having a second staff available can be helpful in case staff need to utilize CPI team transport position...Direct Support Professionals will take a sheet with them when they are in the community with [client C], especially if he is eloping.			

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	The sheet is to cover [client C] up if he removes his clothing anywhere out in the community. If [client C] elopes outside and is out of sight, staff will immediately CALL 911. After 911 is called, the QIDP or on-call will be notified. If single staff, one to one, staff member will follow [client C] while keeping the police and QIDP notified of his whereabouts...." Client C's July 2015 BSP indicated "... [Client C] is to always have 2 on 1 staffing (2 staff to 1 client in community). He is never to be out in the community or at home with just 1 staff...." The BSP indicated demonstrated elopement behavior which was defined as "Evading staff supervision or the leaving area of the group home or workshop without permission or prior knowledge of staff (sic)...There are door alarms on all exterior doors at the group home. Direct support professionals will ensure the door alarms are on at all times and in proper working order. If they are not working appropriately on call will be notified immediately. [Client C] attempts to evade staff supervision on a daily basis. He attempts to elope from day programming multiple times throughout the day...Residential staff will complete 15 minute checks to document his whereabouts...." Client C's BSP indicated facility staff could utilize CPI if			

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	client C eloped and his safety was at risk. Client C's BSP indicated client C was to have 2 staff with the client when at the group home, riding in a car and/or out in the community. Client C's 15 Minute Safety Checks/sheets were reviewed on 10/19/15 at 6:00 PM. Client C's 15 minute checks indicated the facility failed to document 15 minute checks on 10/18/15 from 12:00 PM to 11:45 PM as the 15 minute checklist was blank. Client C's 10/19/15 15 minute check list indicated no 15 minute checks were completed and/or documented from 12:00 AM to 5:48 PM when client C left with 3 staff and 6 other clients to go to a social club at the local mental health department. Client C's 7/16/15 Individual Support Plan (ISP) indicated client C's interdisciplinary team had not met to review the 7/4/15 and 8/11/15 elopement incidents, and/or to ensure client C's monitoring/supervision did not need to be revised to prevent the client's elopement. Client C's ISP also indicated client C did not have a formal training objective in regard to the client's identified lack of pedestrian safety skills. Interview with client A on 10/19/15 at			

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	6:02 PM indicated client C would attempt to leave the group home when he had a behavior. Client A indicated client C had been having a behavior and attacked facility staff with a broom on 7/4/15. Client A indicated there were 2 staff working at the time client C eloped from the group home. Client A indicated 1 staff was passing medications and 1 staff was sitting in the living room with other clients when client C eloped out the back door. Client A stated "I saw him leave out the door and I ran out after him." Client A stated " I asked him to stay in the yard, but he would not listen to me." Client A indicated he attempted to keep client A from eloping as the client had already got past the gate. Client A stated he did grab client C and attempted to pull the client back inside the gate when client C "dropped to the ground." Client A stated "I drug him in gate and locked gate." Client A indicated facility staff did not know client C had eloped out the back door. Client A stated "I was only trying to help staff." Interview with staff #7 on 10/19/15 at 6:15 PM indicated client C had a history of elopement. Staff #7 indicated client C had eloped from the group home in the past 2 weeks. Staff #7 stated "The other day he took off real far. I had to run after him." Staff #7 indicated client C was			

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	sitting in the front room with other clients and staff #7. Staff #7 indicated client C was not upset when the client got and left the living room. Staff #7 indicated he heard the front door alarm and got up and went to the door to see client C running down the street. Staff #7 indicated client C did not go his usual route as the client went down a different way. Staff #7 indicated client C was in line of sight but he was not near the client as the client was running and he was trying to catch up to the client. Staff #7 indicated client C stopped running when the client did not appear to know where he was at and the client returned to the group home with staff #7. When asked if this incident was reported, staff #7 indicated it was not reported to the administration because client #7 was not out of his line of sight. Staff #7 did indicate he was not near the client. Staff #7 indicated client C was on 15 minute checks and facility staff was to keep the client in line of sight when in the group home. Staff #7 indicated client C was to have 2 to 1 staffing when out in the community. When asked how often client C eloped, staff #7 stated "It just depends." Staff #7 indicated the alarms had been on the facility's doors prior to January 2014. When asked how the door alarms were monitored to ensure they were in good working order, staff #7 indicated facility staff would tell the			

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	group home manager if the alarms were not working and/or needed a battery. Interview with staff #1 on 10/19/15 at 7:00 PM indicated when shown the blank 15 minute checks, staff #1 indicated facility staff did not need to document every 15 minutes. Staff #1 stated facility needed to document 15 minute checks "every 2 hours." Staff #1 stated facility staff were to check the door alarms "very 15 minutes at night." Staff #1 indicated facility staff were to contact her if there was a problem with the door alarms. When asked why the sound was low on the back door alarm, staff #1 stated "Maybe the battery has to be changed. It has to be changed all the time." Interview with administrative staff #2 and the QIDP on 10/20/15 at 12:50 PM indicated they were not aware of any recent incident where client C eloped from the group home. Administrative staff #2 and the QIDP indicated client C would go to the corner and watch the cars go by. Administrative staff #2 indicated client C would not go far from the group home. Administrative staff #2 and the QIDP indicated client C was to be in line of sight of staff when he eloped and facility staff did not have to report incidents of elopement where the client was in line of sight. When asked if			

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	facility staff should have documented/reported the recent incident where staff had to run after client C as the staff was not near the client, administrative staff #2 stated "Yes." The QIDP indicated facility staff documented data in regard to run/wanders off. The QIDP indicated there was no documentation on what occurred with the incidents and/or how far the client was ahead of the staff even if the client was in line of staff. Administrative staff #2 and the QIDP indicated being in line of sight of staff did not mean client C was near staff. The QIDP indicated client C did not have a formal training objective in regard to the client's lack of pedestrian safety skills. The QIDP indicated she had spoken to facility staff in regard to checking the door alarms. The QIDP and administrative staff #2 indicated the alarms were not working when client C eloped on 8/11/15. Administrative staff #2 indicated the alarms had been unplugged as the facility's fire alarm system had been worked on earlier in the day. Administrative staff #2 indicated the facility's investigation did not indicate why and/or how the door alarm had been unplugged. When asked how facility staff were to monitor the client, administrative staff #2 and the QIDP stated the facility staff were to know where client C was located "at all times"			

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	in the group home. The QIDP and the administrative staff also indicated 15 minute checks were to be completed by the facility staff. The QIDP indicated facility staff was to document the checks every 2 hours. Administrative staff #2 indicated 15 minute checks were to be done every 15 minutes as indicated. Administrative staff #2 indicated 15 minutes had been put in place on 7/20/15 and were in place when the client eloped on 8/11/15. Administrative staff #2 indicated 2 facility staff had been suspended over the 8/11/15 incident. Administrative staff indicated 4 staff were working at the time client C eloped. Administrative staff #2 indicated the 2 staff who were in the living room were suspended. Administrative staff #2 indicated one of the facility staff had been returned to work as the other staff had been terminated for not participating in the investigation. Administrative staff #2 and the QIDP indicated facility staff had been retrained to leave the door alarms on 8/20/15. Administrative staff #2 stated she went out and bought "cheapy alarms" until the original alarms could be turned back on. The QIDP indicated the facility's maintenance staff went out and turned the alarms back on 8/11/15. When asked how the facility monitored the alarms to make sure they were in good working order,			

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	administrative staff #2 stated she thought the manager checked the alarms and documented them on a "safety checklist." Administrative staff #2 indicated the safety checklist did not include checking the alarms. The QIDP and administrative staff #2 indicated client C's interdisciplinary team did not meet to review client C's supervision/monitoring needs to ensure the client's supervision level needed to be revised, and/or did not specifically indicate how/when facility staff were to ensure the door alarms were in good working order. The QIDP indicated client C's interdisciplinary team had not met to review client C's 7/4/15 and 8/11/15 elopement incidents, and/or data in regard to the client's elopement behavior. Administrative staff #2 indicated the facility's 7/4 and 8/11/15 investigations did not indicate any corrective actions and/or recommendations in regard to the investigations. Administrative staff #1 indicated no other clients were interviewed during the 7/4/15 allegation of client to client abuse. Administrative staff #2 indicated the facility did not conduct an investigation in regard to possible staff neglect as the facility only conducted an investigation in regard to client to client abuse. Administrative staff #1 stated the facility only determined the 8/11/15 allegation of			

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	neglect was "partially substantiated." The facility's policy and procedures were reviewed on 10/19/15 at 3:25 PM. The facility's undated policy and procedure entitled Prohibition of Violations of Individual Rights indicated "Neglect: Failure to provide supervision, training, appropriate care, food, medical care, or medical supervision to an individual." The facility's undated policy indicated the facility "strictly prohibited...neglect...of an individual...." This federal tag relates to complaint #IN00180355. 9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on 2 of 3 allegations of abuse/neglect reviewed, the facility failed to ensure the allegations of neglect were thoroughly investigated regarding clients A and C. Findings include: The facility's reportable incident reports and/or investigations were reviewed on 10/19/15 at 2:45 PM. The facility's	W 0154	**CorrectiveAction(s):** **Tofollow all policies and procedures for all investigations making them inclusiveto include all information that is required at the State and Federal level andthat all allegations or incidents of abuse, neglect, exploitation, andmistreatment are thoroughly investigated and include all imperative informationrequired:**	11/29/2015

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reportable incident reports and/or investigations indicated the following (not all inclusive): -"[Client C] walked out the door at the group home on 7/4/15 at 7pm. The door alarm alerted staff and they followed him outside toward the gate. [Client A] also saw [client C] walking toward the gate and pulled his arm, causing [client C] to fall onto his backside. [Client A] continued to pull [client C] back on the sidewalk, causing a 3inch (sic) by 3 inch abrasion on his backside. Staff redirected [client A] to let go and provided basic first aid to [client C]. Staff gently cleaned the abrasion with soap and water, then applied antibiotic ointment and a bandage over the area. Staff completed an accident incident report and contacted On-Call and the Residential Nurse... [Client C] has a BSP (Behavior Support Plan) that addresses elopement. The group home is equipped with HRC (Human Rights Committee) approved window and door alarms. [Client A] has a BSP that includes physical aggression and attempting to interfere with other consumers during behaviors...." The facility's 7/14/15 Investigation of Peer to Peer Aggression indicated "[Client A] stated that consumer [client C] had tried to leave the group home. He		1.All allegations or incidents ofabuse, neglect, exploitation, mistreatment, will be thoroughly investigated bythe Social Service Coordinator. 2.The Residential Director of QualityAssurance and Social Services was hired. This Director will be supervising theSocial Service Coordinator to provide administrative oversight to allinvestigations. He will ensure that all allegations are thoroughly beinginvestigated as per State and Federal guidelines, as well ensure that eachinvestigation indicates/recommends a corrective action. 3.The Director of Quality Assurance andSocial Services and the Executive Vice president will be reviewing allinvestigations to ensure the investigations are completed thoroughly and allpolicies and procedures for completing investigations are being followed andall State and Federal regulations are being met.	

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	stated that there were no staff because one of the staff was passing medications, and the other staff was watching all of the other consumers. He stated that he then grabbed [client C] and took him back behind the gate. He stated that when he was bringing [client C] back behind the gate he (client C) dropped to the ground and got a scratch on his bottom. He stated that once he got [client C] back behind the gate, he shut and locked the gate." The facility's 7/14/15 peer to peer investigation indicated client C indicated "Consumer [client C] stated that he did not try to get out the door of the home by himself. He stated that [client A] grabbed him by the arm and drug (sic) him back to the home. He stated that he got hurt when [client A] drug (sic) him back to the home. He stated that the staff that was working at the time of the incident helped him." The facility's 7/14/15 investigation of the client to client aggression incident indicated there were 2 staff working at the group home at the time of the incident. The facility's investigation indicated one staff (staff #2) was passing medications and the other staff (staff #3) ran out behind client C when he left the group home, but client A was able to get			

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	to client C first. The facility's investigation indicated staff #3 was interviewed on 7/14/15. Staff #3's 7/14/15 witness statement indicated "1.) What happened between [client C] and [client A] the other day? [Client C] ran out of the house. I ran after him but [client A] grabbed him before I could get to him. I told [client A] to let go of him. Before [client A] let go of him [client C] fell to the ground. [Client A] then drug (sic) him back behind the gat (sic). 2.) Why did [client A] drag [client C] back to the home? He said he was just trying to help us. 3.) What did you do when the incident occurred? I helped [client C] back up. Then talked to [client A] about letting staff do their job." Staff #2's 7/8/15 witness statement indicated "1.) What happened between [client C] and [client A] the other day? "[Client C] ran out. [Staff #3] was running after him. [Client A] got to him first and grabbed his arm to pull him back to the house. [Client C] dropped to the ground. [Client A] continued to drag [client C] towards the house. 2.) Why did [client A] drag [client C] back to the home? Just go bring him back to the house. 3.) What did you do when the incident occurred? I stopped passing medications and went outside. We then brought [client C] back into the house."			

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	The facility's 7/14/15 investigation indicated "It was determined through a thorough investigation that this was a simple peer to peer aggression due to consumer [client A] responding to consumer [client C] in a negative manner. [Client A] grabbed [client C] by the arm and drug (sic) him back towards the home to keep him from running down the road. Staff were following [client C], and informed [client A] to let go of [client C]. Staff immediately separated the two consumers from one another." The facility's 7/14/15 investigation indicated the facility neglected to conduct an investigation in regard to neglect due to the client's 7/4/15 elopement incident as client A indicated staff were not around when client C eloped from the group home. The facility's investigation failed to specifically indicate where staff #2 and staff #3 were located in the group home when client C eloped from the group home. The facility's investigation failed to include any additional client interviews in regard to the 7/4/15 incident. The facility's investigation failed to clearly indicate/explain how/why client A was able to get to client C before staff were able to get to the client. The facility's investigation failed to indicate/include any recommendations and/or corrective actions in regard to the 7/4/15 incident.			

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	-8/11/15 "On 8/11/2015 at 4:20pm Residential house manager (staff #1) received a phone call from the Residential Group Home Nurse that [client C] had eloped from the group home and was on the corner of [name of street] and [name of street] without staff. The Residential House Nurse stopped and got [client C] into her personal vehicle and took him for a drive. Residential House Manager informed the Residential Director at 4:29pm. Residential Director immediately suspended the direct support professionals on shift at the time of the elopement incident, pending investigation. [Client C] has no injuries or mental trauma due to this incident. Initial findings is (sic) that [client C] was out of the home for no more than 3-5 minutes. [Client C] has a BSP that addresses targeted behaviors including elopement and elopement risk plan. [Client C] has a BSP and an elopement plan put in place and all direct Support (sic) professionals have been trained on it prior to working with him. The group home currently has door alarms which are HRC approved. Initial findings were the door alarms were not working at the time of this incident. Direct Support professionals (sic) on shift at time of incident will remain suspended pending			

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	outcome of investigation. [Client C] has been counseled as per the dangers in him sneaking out of the home without telling staff." The facility's 8/18/15 investigation indicated there were 4 staff working at the time of the incident and "The two staff (staff #4 and #5) that were sitting in the living room at the time [client C] eloped from the home were immediately suspended, pending an investigation. The facility's investigation indicated all 8 clients were present at the group home at the time of the incident. The facility's investigation indicated several group home clients had indicated client C left the group home on 8/11/15. Client G's 8/12/15 witness statement indicated "...He (client C) ran out. 6.) What were staff doing when [client C] ran out? In the office. I don't know. 7.) Where were you when [client C] ran out? In my room...." Client C's 8/12/15 witness statement indicated "...I sneak out the back door. 5.) Were the alarms on and working? Not go off. 6.) Did staff see? Just [staff #6]...." Client E's 8/12/15 witness statement indicated the alarms were not working at			

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	the group home. Client D's 8/12/15 witness statement indicated "1.) What did you do when you got home from workshop last night? I was sitting in the chair and then my friend came over. [Staff #4] was sitting (on) the couch. We didn't hear the bell go off. 2.) Who all was sitting in the living room? Me, [client A], [staff #4] and [staff #5]. 3.) Were there any behaviors? Except for [client C] eloping. 4.) What were [staff #4] and [staff #5] doing? Watching T.V. [staff #6] was passing medications. [Staff #1] was working on her papers in the office." Client B's 8/12/15 witness statement indicated client C had run away and staff #4 went after the client (first incident of elopement). The witness statement indicated the neighbors called the police, and the door alarms did not work until the new door alarms were delivered and placed on the doors on 8/11/15 (after the incident). RN #1's 8/12/15 witness statement indicated she found client C "sitting 'indian style' on the sidewalk." The witness statement indicated she stopped and asked client C to come with her. The witness statement indicated she went to the group home and told a staff person			

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	who was standing in the driveway she was going to take client C for a ride and to get the client something to drink. RN #1's witness statement indicated she immediately called staff #1 when she saw client C sitting on the sidewalk without staff. RN #1's 8/12/15 witness statement indicated "...As I was driving, I asked [client C] if he was upset. He stated that he had a bad day at work and tried to run off at work and fell down at work. I then asked if he had gotten hurt when he fell down at work. He showed me his right knee that had a band aid on it. I then asked [client C] if it was a good idea to run off when he was upset. He said no, but at least I wasn't in the road. The residential director then contacted me (RN #1) via phone. She asked if the alarms were on in the group home when [client C] was found. I replied that I did not know because [client C] and I went to get a drink and had not yet returned to the group home. She asked me to ask [client C] if he told anyone he was leaving. [Client C] replied no. She then asked me to ask [client C] if the door alarms went off when he left the house. [Client C] replied no...." Staff #5's 8/12/15 witness statement indicated staff #5 came into work at 4:00 PM on 8/11/15. The staff's witness statement indicated the back door was			

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	open when she came into work and she closed the back door. The witness statement indicated the alarms on the door did not go off. The staff's witness statement indicated client C eloped from the group home and went out the back door. Staff #5's 8/12/15 witness statement indicated "...I said [client C] is eloping. I followed him to the corner. [Staff #3] brought his pictures to the corner. Total was about 20 minutes. This happened shortly after 4pm. We all came back to the house, and I went downstairs to the restroom. When I came up he was gone. [Staff #4] was on the couch with all of the consumers from earlier on the couch. [Client E] was in his room. This was about 4:30ish. The alarms do not go off the way they are supposed to. I think [client C] went out when [staff #3] left. [Client C] has problems getting out of the gate. The alarm system never works right. 9.) How long was [client C] gone for? 5 minutes at the most." Staff #1's 8/12/15 witness statement indicated she and staff #6 were in the office, staff #5 was in the kitchen and staff #4 was in the living room with some clients. Staff #1's witness statement indicated "...Was the door open or closed? It was shut. But [staff #4] went outside to smoke with [client F]. The			

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	alarm was not working. Maintenance came back to fix the alarm...." Staff #6's 8/12/15 witness statement indicated he was in the office when RN #1 called to say client C was on a street corner. Staff #6 indicated the alarm had not been on and the door was closed when the clients came home. Staff #6's 8/12/15 witness statement indicated "...Did you find the alarm unplugged? Yes. [Staff #1] and I started messing with the alarm after [client C] eloped. I found it unplugged. We had to reset the alarm. 12.) Have you ever seen the alarm unplugged before? No. I don't mess with them. It's not mine to mess with." Staff #3's 8/12/15 witness statement indicated client C got upset when he came home because he couldn't find his pictures. The witness statement indicated "...I grabbed his hands and talked to him. He went outside and me and [staff #5] ran outside with him. [Client E] was standing by the van so I talked to him. [Staff #6] came out and talked to me. I went in the office and left. I sat out in my care (sic) on the phone until about 4:15pm...." Staff #3's witness statement indicated client C was in the house when he was sitting in his car on the phone. The staff indicated the alarm was not on			

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	the door at the group home. The facility's investigation indicated client C had attempted to elope prior to the second elopement when the client left the group home. The 8/18/15 investigation indicated the alarms were not working on the back door but were fixed after the second elopement incident occurred. The 8/18/15 investigation did not specifically indicate the facility substantiated neglect. The facility's investigation indicated "...Partially supports event as described/alleged...." The facility's investigation failed to indicate why the alarms had been turned off at the group home, who turned the alarms off, and/or failed to indicate/include any recommendations and/or corrective actions in regard to the 8/11/15 elopement incident. Interview with client A on 10/19/15 at 6:02 PM indicated client C would attempt to leave the group home when he had a behavior. Client A indicated client C had been having a behavior and attacked facility staff with a broom on 7/4/15. Client A indicated there were 2 staff working at the time client C eloped from the group home. Client A indicated 1 staff was passing medications and 1 staff was sitting in the living room with other clients when client C eloped out the back door. Client A stated "I saw him			

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	leave out the door and I ran out after him." Client A stated " I asked him to stay in the yard, but he would not listen to me." Client A indicated he attempted to keep client A from eloping as the client had already got past the gate. Client A stated he did grab client C and attempted to pull the client back inside the gate when client C "dropped to the ground." Client A stated "I drug him in gate and locked gate." Client A indicated facility staff did not know client C had eloped out the back door. Client A stated "I was only trying to help staff." Interview with administrative staff #2 and the QIDP on 10/20/15 at 12:50 PM indicated the alarms were not working when client C eloped on 8/11/15. Administrative staff #2 indicated the alarms had been unplugged as the facility's fire alarm system had been worked on earlier in the day. Administrative staff #2 indicated facility's investigation did not indicate why and/or how the door alarm had been unplugged. Administrative staff #2 indicated 15 minutes had been put in place on 7/20/15 and were in place when the client eloped on 8/11/15. Administrative staff #2 indicated 2 facility staff had been suspended over the 8/11/15 incident. Administrative staff indicated 4 staff were working at the time			

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	client C eloped. Administrative staff #2 indicated the 2 staff who were in the living room were suspended. Administrative staff #2 indicated the facility's 7/4 and 8/11/15 investigations did not indicate any corrective actions and/or recommendations on the investigations. Administrative staff #1 indicated no other clients were interviewed during the 7/4/15 allegation of client to client abuse. Administrative staff #2 indicated the facility did not conduct an investigation in regard to possible staff neglect as the facility only conducted an investigation in regard to client to client abuse. Administrative staff #1 stated the facility only determined the 8/11/15 allegation of neglect was "partially substantiated." This federal tag relates to complaint #IN00180355. 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, interview and record review for 2 of 3 allegations of abuse and/or neglect reviewed, the facility's investigations failed to include recommendations and/or corrective	W 0157	**Tofollow all policies and procedures for all investigations making them inclusiveto include all information that is required at the State and Federal level andthat all allegations or incidents of**	11/29/2015

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	measures the facility took in regard to the elopement incidents involving clients A and C. Findings include: The facility's reportable incident reports and/or investigations were reviewed on 10/19/15 at 2:45 PM. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive): -"[Client C] walked out the door at the group home on 7/4/15 at 7pm. The door alarm alerted staff and they followed him outside toward the gate. [Client A] also saw [client C] walking toward the gate and pulled his arm, causing [client C] to fall onto his backside. [Client A] continued to pull [client C] back on the sidewalk, causing a 3inch (sic) by 3 inch abrasion on his backside. Staff redirected [client A] to let go and provided basic first aid to [client C]. Staff gently cleaned the abrasion with soap and water, then applied antibiotic ointment and a bandage over the area. Staff completed an accident incident report and contacted On-Call and the Residential Nurse... [Client C] has a BSP (Behavior Support Plan) that addresses elopement. The group home is equipped with HRC (Human Rights Committee) approved		**abuse, neglect, exploitation, andmistreatment are thoroughly investigated and include all imperative informationrequired:** 1.Allallegations or incidents of abuse, neglect, exploitation, mistreatment, will bethoroughly investigated by the Social Service Coordinator. 2.TheResidential Director of Quality Assurance and Social Service will besupervising the Social Service Coordinator to provide administrative oversighton all investigations. He will ensure that all allegations are thoroughly beinginvestigated as per State and federal guidelines, as well ensure that eachinvestigation indicates/recommends a corrective action. 3.TheDirector of Quality Assurance and Social Services and the Executive Vicepresident will be reviewing all investigations to ensure the investigations arecompleted thoroughly and all policies and procedures for completinginvestigations are being followed and all State and Federal regulations are beingmet. ***1.“The facility failed to implement itswritten policy and procedures to prevent neglect of client C in regards to theclient’s elopement behavior. The facility failed to include/indicate anyrecommendations and/or corrective actions in regards to***	

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	window and door alarms. [Client A] has a BSP that includes physical aggression and attempting to interfere with other consumers during behaviors. [Client C] has a falling risk plan in place due to his poor balance. All staff are trained on BSPs, Risk Plans, and First Aid before working with Consumers." The facility's 7/14/15 Investigation of Peer to Peer Aggression indicated "[Client A] stated that consumer [client C] had tried to leave the group home. He stated that there were no staff because one of the staff was passing medications, and the other staff was watching all of the other consumers. He stated that he then grabbed [client C] and took him back behind the gate. He stated that when he was bringing [client C] back behind the gate he (client C) dropped to the ground and got a scratch on his bottom. He stated that once he got [client C] back behind the gate, he shut and locked the gate." The facility's 7/14/15 peer to peer investigation indicated client C indicated "Consumer [client C] stated that he did not try to get out the door of the home by himself. He stated that [client A] grabbed him by the arm and drug (sic) him back to the home. He stated that he got hurt when [client A] drug (sic) him		***client C's elopement"*** - **CorrectiveAction(s): Todevelop, implement, and follow all policies and procedures that prohibit abuse,neglect, exploitation, and mistreatment:** 1.TheQualified Intellectual Disabilities Professional (QIDP) will revise the BehaviorSupport Plan (BSP) to include a Behavior tracking data sheet to track theelopement incident, what route the elopement occurred, how long, and wherestaff was during the incident. The BSP will also have a stop light chart addedfor assistance with staff monitoring in regards to what level client C is onred-high alert, yellow-cautions, green- safe; Elopement Risk Plan, andIndividual Support Plan to include incident of elopement and protocol to followto prevent elopement. The QIDP will add informal program goals to addressclient C's elopement and Pedestrian safety skills. The QIDP will implementincentive plans based around the targeted behavior of elopement to encouragedirection and to assist in preventing incidents of elopement. The QIDP willtrain all staff working in the home on all revisions and additions of plans. Recordsof trainings will be completed following trainings and submitted to theResidential Director for administrative	

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	15G802		10/30/2015

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	back to the home. He stated that the staff that was working at the time of the incident helped him." The facility's 7/14/15 investigation of the client to client aggression incident indicated there were 2 staff working at the group home at the time of the incident. The facility's investigation indicated one staff (staff #2) was passing medications and the other staff (staff #3) ran out behind client C when he left the group home, but client A was able to get to client C first. The facility's investigation indicated staff #2 was interviewed on 7/14/15. Staff #3's 7/14/15 witness statement indicated "1.) What happened between [client C] and [client A] the other day? [Client C] ran out of the house. I ran after him but [client A] grabbed him before I could get to him. I told [client A] to let go of him. Before [client A] let go of him [client C] fell to the ground. [Client A] then drug (sic) him back behind the gat (sic). 2.) Why did [client A] drag [client C] back to the home? He said he was just trying to help us. 3.) What did you do when the incident occurred? I helped [client C] back up. Then talked to [client A] about letting staff do their job." Staff #2's 7/8/15 witness statement indicated "1.) What happened between		oversight (Appendix A). 2.TheResidential House Manager will retrain all staff working in the home on BonaVista's Policy for abuse, neglect, exploitation, and mistreatment. Records oftraining will be completed following trainings and submitted to the ResidentialDirector for administrative oversight (Appendix B). 3.TheResidential House Manager and the Residential Lead DSP will check on the door/windowalarms daily to ensure they are in working condition. The Residential HouseManager will designate one staff per shift to check the door/window alarms whenthey arrive and when they leave shift to ensure that the alarms are in goodworking condition. This will be documented on a safety check list sheet. 4.TheResidential House Manager will complete a safety check list every Monday toensure that the Group Home door/window alarms are working properly and are loudenough for staff to hear them. If the alarms are not working properly, theResidential House Manager will contact Maintenance immediately to get the alarmfixed. The Residential House manager will turn in a safety report every Mondayto the Residential Directors, Executive Vice President, and the Director	

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	[client C] and [client A] the other day? "[Client C] ran out. [Staff #3] was running after him. [Client A] got to him first and grabbed his arm to pull him back to the house. [Client C] dropped to the ground. [Client A] continued to drag [client C] towards the house. 2.) Why did [client A] drag [client C] back to the home? Just go bring him back to the house. 3.) What did you do when the incident occurred? I stopped passing medications and went outside. We then brought [client C] back into the house." The facility's 7/14/15 investigation indicated "It was determined through a thorough investigation that this was a simple peer to peer aggression due to consumer [client A] responding to consumer [client C] in a negative manner. [Client A] grabbed [client C] by the arm and drug (sic) him back towards the home to keep him from running down the road. Staff were following [client C], and informed [client A] to let go of [client C]. Staff immediately separated the two consumers from one another." The facility's 7/14/15 investigation indicated failed to indicate/include any recommendations and/or corrective actions in regard to the 7/4/15 incident. -8/11/15 "On 8/11/2015 at 4:20pm Residential house manager (staff #1) received a phone call from the		ofMaintenance for additional administrative oversight (Appendix C). The Residential HouseManager and the Residential Lead DSP will go over all monitoring, trackingsheets, and documentation weekly in regards to elopement behaviors. TheResidential House Manager 1.andResidential Team Lead will fax all elopement tracking data to the QIDP biweeklyto review unless there is an incident of elopement then the QIDP will becontacted immediately and a team Inner Disciplinary plan. All plans and revisions that are made at theIDT meetings all staff that work in the home will be trained on. All records oftraining will be completed following trainings and submitted to the ResidentialDirector for administrative oversight (Appendix F).	

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	Residential Group Home Nurse that [client C] had eloped from the group home and was on the corner of [name of street] and [name of street] without staff. The Residential House Nurse stopped and got [client C] into her personal vehicle and took him for a drive. Residential House Manager informed the Residential Director at 4:29pm. Residential Director immediately suspended the direct support professionals on shift at the time of the elopement incident, pending investigation. [Client C] has no injuries or mental trauma due to this incident. Initial findings is (sic) that [client C] was out of the home for no more than 3-5 minutes. [Client C] has a BSP that addresses targeted behaviors including elopement and elopement risk plan. [Client C] has a BSP and an elopement plan put in place and all direct Support (sic) professionals have been trained on it prior to working with him. The group home currently has door alarms which are HRC approved. Initial findings were the door alarms were not working at the time of this incident. Direct Support professionals (sic) on shift at time of incident will remain suspended pending outcome of investigation. [Client C] has been counseled as per the dangers in him sneaking out of the home without telling staff."			

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	The facility's 8/18/15 investigation indicated there were 4 staff working at the time of the incident and "The two staff (staff #4 and #5) that were sitting in the living room at the time [client C] eloped from the home were immediately suspended, pending an investigation. The facility's investigation indicated all 8 clients were present at the group home at the time of the incident. The facility's investigation indicated several group home clients had indicated client C left the group home on 8/11/15. Client G's 8/12/15 witness statement indicated "...He (client C) ran out. 6.) What were staff doing when [client C] ran out? In the office. I don't know. 7.) Where were you when [client C] ran out? In my room...." Client C's 8/12/15 witness statement indicated "...I sneak out the back door. 5.) Were the alarms on and working? Not go off. 6.) Did staff see? Just [staff #6]...." Client E's 8/12/15 witness statement indicated the alarms were not working at the group home. Client D's 8/12/15 witness statement indicated "1.) What did you do when you			

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	got home from workshop last night? I was sitting in the chair and then my friend came over. [Staff #4] was sitting (on) the couch. We didn't hear the bell go off. 2.) Who all was sitting in the living room? Me, [client A], [staff #4] and [staff #5]. 3.) Were there any behaviors? Except for [client C] eloping. 4.) What were [staff #4] and [staff #5] doing? Watching T.V. [staff #6] was passing medications. [Staff #1] was working on her papers in the office." Client B's 8/12/15 witness statement indicated client C had run away and staff #4 went after the client (first incident of elopement). The witness statement indicated the neighbors called the police, and the door alarms did not work until the new door alarms were delivered and placed on the doors on 8/11/15 (after the incident). RN #1's 8/12/15 witness statement indicated she found client C "sitting 'indian style' on the sidewalk." The witness statement indicated she stopped and asked client C to come with her. The witness statement indicated she went to the group home and told a staff person who was standing in the driveway she was going to take client C for a ride and to get the client something to drink. RN #1's witness statement indicated she			

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	immediately called staff #1 when she saw client C sitting on the sidewalk without staff. RN #1's 8/12/15 witness statement indicated "...As I was driving, I asked [client C] if he was upset. He stated that he had a bad day at work and tried to run off at work and fell down at work. I then asked if he had gotten hurt when he fell down at work. He showed me his right knee that had a band aid on it. I then asked [client C] if it was a good idea to run off when he was upset. He said no, but at least I wasn't in the road. The residential director then contacted me (RN #1) via phone. She asked if the alarms were on in the group home when [client C] was found. I replied that I did not know because [client C] and I went to get a drink and had not yet returned to the group home. She asked me to ask [client C] if he told anyone he was leaving. [Client C] replied no. She then asked me to ask [client C] if the door alarms went off when he left the house. [Client C] replied no...." Staff #5's 8/12/15 witness statement indicated staff #5 came into work at 4:00 PM on 8/11/15. The staff's witness statement indicated the back door was open when she came into work and she closed the back door. The witness statement indicated the alarms on the door did not go off. The staff's witness			

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	statement indicated client C eloped from the group home and went out the back door. Staff #5's 8/12/15 witness statement indicated "...I said [client C] is eloping. I followed him to the corner. [Staff #3] brought his pictures to the corner. Total was about 20 minutes. This happened shortly after 4pm. We all came back to the house, and I went downstairs to the restroom. When I came up he was gone. [Staff #4] was on the couch with all of the consumers from earlier on the couch. [Client E] was in his room. This was about 4:30ish. The alarms do not go off the way they are supposed to. I think [client C] went out when [staff #3] left. [Client C] has problems getting out of the gate. The alarm system never works right. 9.) How long was [client C] gone for? 5 minutes at the most." Staff #1's 8/12/15 witness statement indicated she and staff #6 were in the office, staff #5 was in the kitchen and staff #4 was in the living room with some clients. Staff #1's witness statement indicated "...Was the door open or closed? It was shut. But [staff #4] went outside to smoke with [client F]. The alarm was not working. Maintenance came back to fix the alarm...." Staff #6's 8/12/15 witness statement			

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	indicated he was in the office when RN #1 called to say client C was on a street corner. Staff #6 indicated the alarm had not been on and the door was closed when the clients came home. Staff #6's 8/12/15 witness statement indicated "...Did you find the alarm unplugged? Yes. [Staff #1] and I started messing with the alarm after [client C] eloped. I found it unplugged. We had to reset the alarm. 12.) Have you ever seen the alarm unplugged before? No. I don't mess with them. It's not mine to mess with." Staff #3's 8/12/15 witness statement indicated client C got upset when he came home because he couldn't find his pictures. The witness statement indicated "...I grabbed his hands and talked to him. He went outside and me and [staff #5] ran outside with him. [Client E] was standing by the van so I talked to him. [Staff #6] came out and talked to me. I went in the office and left. I sat out in my care (sic) on the phone until about 4:15pm...." Staff #3's witness statement indicated client C was in the house when he was sitting in his car on the phone. The staff indicated the alarm was not on the door at the group home. The facility's investigation indicated client C had attempted to elope prior to the second elopement when the client left the group			

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	home. The 8/18/15 investigation indicated the alarms were not working on the back door but was (sic) fixed after the second elopement incident occurred. The 8/18/15 investigation did not specifically indicate the facility substantiated neglect. The facility's investigation indicated "...Partially supports event as described/alleged...." The facility's investigation failed to indicate/include any recommendations and/or corrective actions in regard to the 8/11/15 elopement incident. During the 10/19/15 observation period between 5:25 PM and 7:15 PM, at the group home, client E answered the door. An alarm was heard on the back door. The door alarm was low in volume. The TV was on in the living room, staff and clients were in the kitchen and in their bedrooms. The front door was opened and the 2 alarms were on the front door and both alarms sounded in a loud tone which could be heard. The living room was not in sight of the back and/or front door of the group home. The facility's office was located in the hallway (first door to the left). The front and/or back doors could not be seen from the office area. At 5:54 PM, staff #7 tested the door alarms to see if they could be heard in the living room area, in the office and/or at the back of the house. The back			

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	door alarm could barely be heard in the office area, living room area and/or at the back of the house. Interview with staff #7 on 10/19/15 at 6:15 PM when asked why the sound of the alarm was low, staff #7 stated "We have heard it for so long, we can just hear it. May need new batteries." Staff #7 indicated the back door alarm was not as loud as the front door alarm. Interview with staff #1 on 10/19/15 at 7:00 PM indicated when shown the blank 15 minute checks indicated facility staff did not need to document every 15 minutes. Staff #1 stated facility needed to document 15 minute checks "every 2 hours." Staff #1 stated facility staff were to check the door alarms "very 15 minutes at night." Staff #1 indicated facility staff were to contact her if there was a problem with the door alarms. When asked why the sound was low on the back door alarm, staff #1 stated "Maybe the battery has to be changed. It has to be changed all the time." Interview with administrative staff #2 and the QIDP on 10/20/15 at 12:50 PM indicated the alarms were not working when client C eloped on 8/11/15. The QIDP indicated she had spoken to facility staff in regard to checking the door alarms. The QIDP and administrative			

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	staff #2 indicated the alarms had been unplugged as the facility's fire alarm system had been worked on earlier in the day. Administrative staff #2 indicated 2 facility staff had been suspended over the 8/11/15 incident. Administrative staff indicated 4 staff were working at the time client C eloped. Administrative staff #2 indicated the 2 staff who were in the living room were suspended. Administrative staff #2 indicated one of the facility staff had been returned to work as the other staff had been terminated for not participating in the investigation. Administrative staff #2 and the QIDP indicated facility staff had been retrained to leave the door alarms on 8/20/15. Administrative staff #2 stated she went out and bought "cheapy alarms" until the original alarms could be turned back on. The QIDP indicated the facility's maintenance staff went out and turned the alarms back on 8/11/15. When asked how the facility monitored the alarms to make sure they were in good working order, administrative staff #2 stated she thought the manager checked the alarms and documented them on a "safety checklist." Administrative staff #2 indicated the safety checklist did not include checking the alarms. Administrative staff #2 indicated the facility's 7/4 and 8/11/15 investigations did not indicate any corrective actions			

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	and/or recommendations in regard to the investigations. Administrative staff #1 stated the facility only determined the 8/11/15 allegation of neglect was "partially substantiated." This federal tag relates to complaint #IN00180355. 9-3-2(a)			
W 0227 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on interview and record review for 1 of 4 sampled clients (C), the client's Individual Support Plan (ISP) failed to address the client's identified training needs in regard to pedestrian safety. Findings include: The facility's reportable incident reports and/or investigations were reviewed on 10/19/15 at 2:45 PM. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive): -"[Client C] walked out the door at the group home on 7/4/15 at 7pm. The door	W 0227	**CorrectiveAction(s): Toprovide and implement a formal training objective for client C's identifiedtraining need/pedestrian safety skills.** 1.TheQualified Intellectual Disabilities Professional (QIDP) will implement formaltraining programs for Client C's pedestrian safety skills. The QIDP will reviseclient C's Individual Support Plan (ISP) to reflect the addition of the formalprogramming of the pedestrian safety skills. All staff working in the home willbe trained on all revisions and additions to the plan. Records of training willbe completed following trainings and submitted to the Residential Director	11/29/2015

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	alarm alerted staff and they followed him outside toward the gate. [Client A] also saw [client C] walking toward the gate and pulled his arm, causing [client C] to fall onto his backside. [Client A] continued to pull [client C] back on the sidewalk, causing a 3inch (sic) by 3 inch abrasion on his backside. Staff redirected [client A] to let go and provided basic first aid to [client C]. Staff gently cleaned the abrasion with soap and water, then applied antibiotic ointment and a bandage over the area. Staff completed an accident incident report and contacted On-Call and the Residential Nurse... [Client C] has a BSP (Behavior Support Plan) that addresses elopement. The group home is equipped with HRC (Human Rights Committee) approved window and door alarms. [Client A] has a BSP that includes physical aggression and attempting to interfere with other consumers during behaviors. [Client C] has a falling risk plan in place due to his poor balance. All staff are trained on BSPs, Risk Plans, and First Aid before working with Consumers." -8/11/15 "On 8/11/2015 at 4:20pm Residential house manager (staff #1) received a phone call from the Residential Group Home Nurse that [client C] had eloped from the group home and was on the corner of [name of		foradministrative oversight (Appendix G).	

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	15G802		10/30/2015

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	street] and [name of street] without staff. The Residential House Nurse stopped and got [client C] into her personal vehicle and took him for a drive. Residential House Manager informed the Residential Director at 4:29pm. Residential Director immediately suspended the direct support professionals on shift at the time of the elopement incident, pending investigation. [Client C] has no injuries or mental trauma due to this incident. Initial findings is (sic) that [client C] was out of the home for no more than 3-5 minutes...." Client C's record was reviewed on 10/20/15 at 11:33 AM. Client C's 7/18/14 Risk Management Assessment Plan (RMAP) indicated "...[Client C] has a history of elopement from the group home and workshop. [Client C] during times of aggression has a history of eloping from staff's presence...[Client C] has a history of going out on sidewalks in warm weather and throwing rocks at cars, strip his clothes off, and make threats at individuals passing by. [Client C] has a past history of elopement as well...[Client C] does not display safe pedestrian skills. He has run into oncoming traffic and lied down on the road. He does not understand basic safety signs and does not look before crossing streets or			

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	entering intersections...When [client C] is out of line of sight his safety is compromised due to not displaying safe pedestrian skills. Staff will document any unsafe activity in their daily notes...." Client C's 7/16/15 ISP indicated client C did not have a formal training objective in regard to the client's identified training need/pedestrian safety skills. Interview with staff #7 on 10/19/15 at 6:15 PM stated he did not think client C would cross the street and/or walk out in front of a car as the client would get "scared easy." Staff #7 was not sure if client C could independently cross the street. Interview with administrative staff #2 and the QIDP on 10/20/15 at 12:50 PM indicated client C required staff supervision when he was in the community. The QIDP indicated client C did not have a formal training objective in regard to the client's lack of pedestrian safety skills. This federal tag relates to complaint #IN00180355. 9-3-4(a)			

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W 0240 Bldg. 00	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on interview and record review for 1 of 4 sampled clients (C), the client's Individual Support Plan (ISP) and/or Behavior Support Plan (BSP) failed to indicate how often the facility staff were to monitor/check the door/window alarms to ensure the alarms were in good working condition. Findings include: The facility's reportable incident reports and/or investigations were reviewed on 10/19/15 at 2:45 PM. The facility's 8/11/15 reportable incident report indicated "On 8/11/2015 at 4:20pm Residential house manager (staff #1) received a phone call from the Residential Group Home Nurse that [client C] had eloped from the group home and was on the corner of [name of street] and [name of street] without staff. The Residential House Nurse stopped and got [client C] into her personal vehicle and took him for a drive. Residential House Manager informed the Residential Director at 4:29pm. Residential director immediately suspended the direct support professionals on shift at the time of the	W 0240	1.TheResidential House Manager and the Residential Lead DSP will check on the door/windowalarms daily to ensure they are in working condition. The Residential HouseManager will designate one staff per shift to check the door/window alarms whenthey arrive and when they leave shift to ensure that the alarms are in goodworking condition. This will be documented on a safety check sheet. 2.TheResidential House Manager will complete a safety check list every Monday toensure that the Group Home door/window alarms are working properly and are loudenough for staff to hear them. If the alarms are not working properly, theResidential House Manager will contact Maintenance immediately to get it fixed.The Residential House manager will submit in a safety report every Monday tothe Residential Directors, Executive Vice President, and the Director of Maintenancefor additional administrative oversight (Appendix C). 3.TheResidential House Manager and the Residential Lead DSP will go over allmonitoring, tracking sheets,	11/29/2015

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	elopement incident, pending investigation. [Client C] has no injuries or mental trauma due to this incident. Initial findings is (sic) that [client C] was out of the home for no more than 3-5 minutes. [Client C] has a BSP that addresses targeted behaviors including elopement and elopement risk plan. [Client C] has a BSP and an elopement plan put in place and all direct Support (sic) professionals have been trained on it prior to working with him. The group home currently has door alarms which are HRC approved. Initial findings were the door alarms were not working at the time of this incident...." Client C's record was reviewed on 10/20/15 at 11:33 AM. Client C's 7/16/15 Elopement Risk Plan indicated the group home had window and door alarms due to client C's elopement behavior. Client C's July 2015 BSP indicated "... [Client C] is to always have 2 on 1 staffing (2 staff to 1 client in community). He is never to be out in the community or at home with just 1 staff...." The BSP indicated demonstrated elopement behavior which was defined as "Evading staff supervision or the leaving area of the group home or workshop without permission or prior		and documentation weekly in regards to elopementbehaviors. The Residential House Manager and Residential Lead DSP will fax allelopement tracking data to the QIDP biweekly to review unless there is an incidentof elopement, then the QIDP will be contacted immediately, an inter-disciplinaryteam (IDT) meeting will be held to discuss the elopement and to create apreventative plan. All staff working inthe home will be trained on all revised plans. Records of training will becompleted following trainings and submitted to the Residential Director foradministrative oversight (Appendix F). 4.TheQualified Intellectual Disability Professional (QIDP) will revise client C'sBehavior Support Plan (BSP) to include all monitoring and tracking informationthat is to be implemented in regards to the group home door/window alarms.Staff working in the home will be trained on all revised plans. Records oftraining will be completed following trainings and submitted to the ResidentialDirector for administrative oversight (Appendix H).	

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	knowledge of staff (sic)...There are door alarms on all exterior doors at the group home. Direct support professionals will ensure the door alarms are on at all times and in proper working order. If they are not working appropriately on call will be notified immediately. [Client C] attempts to evade staff supervision on a daily basis. He attempts to elope from day programming multiple times throughout the day...." Client C's BSP and/or ISP did not specifically indicate how and/or when facility staff were to monitor/check the door and/or window alarms to ensure they were in good working order. Interview with staff #7 on 10/19/15 at 6:15 PM indicated client C had a history of elopement. When asked how often client C eloped, staff #7 stated "It just depends." Staff #7 indicated the alarms had been on the facility's doors prior to January 2014. When asked how the door alarms were monitored to ensure they were in good working order, staff #7 indicated facility staff would tell the group home manager if the alarms were not working and/or needed a battery. Interview with staff #1 on 10/19/15 at 7:00 PM stated facility staff were to check the door alarms "every 15 minutes at night." Staff #1 indicated facility staff			

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	were to contact her if there was a problem with the door alarms. When asked why the sound was low on the back door alarm, staff #1 stated "Maybe the battery has to be changed. It has to be changed all the time." Interview with administrative staff #2 and the QIDP on 10/20/15 at 12:50 PM indicated the alarms were not working when client C eloped on 8/11/15. Administrative staff #2 indicated the alarms had been unplugged as the facility's fire alarm system had been worked on earlier in the day. Administrative staff #2 and the QIDP indicated facility staff had been retrained to leave the door alarms on 8/20/15. Administrative staff #2 stated she went out and bought "cheapy alarms" until the original alarms could be turned back on. The QIDP indicated the facility's maintenance staff went out and turned the alarms back on 8/11/15. When asked how the facility monitored the alarms to make sure they were in good working order, administrative staff #2 stated she thought the manager checked the alarms and documented them on a "safety checklist." Administrative staff #2 indicated the safety checklist did not include checking the alarms. The QIDP and administrative staff #2 indicated client C's risk plan and/or BSP did not			

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	specifically indicate how/when facility staff were to ensure the door alarms were in good working order. This federal tag relates to complaint #IN00180355. 9-3-4(a)			
W 0252 Bldg. 00	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. Based on interview and record review for 1 of 4 sampled clients (C), the facility failed to ensure facility staff documented/monitored the client every 15 minutes as indicated by the client's Behavior Support Plan (BSP). The facility failed to ensure facility staff accurately collected/documented behavior data/incidents when they occurred. Findings include: The facility's reportable incident reports and/or investigations were reviewed on 10/19/15 at 2:45 PM. The facility's reportable incident reports and/or investigations indicated the following (not all inclusive):	W 0252	**CorrectiveAction(s):** **Toensure that facility staff are completing all documentation/monitoringaccording to client C's Behavior Support Plan (BSP), Individual Support Plan(ISP), risk plans, program goals. To ensure that facility staff are accuratelycollecting/documenting behavior date/incidents when they occur.** 1.TheResidential House Manager and the Residential Lead DSP will review allmonitoring, tracking sheets, and documentation weekly in regards to elopementbehaviors. The Residential House Manager and Residential Lead DSP will fax allelopement tracking data to the QIDP biweekly to review, unless there is anincident of elopement then the QIDP will be contacted	11/29/2015

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	-"[Client C] walked out the door at the group home on 7/4/15 at 7pm. The door alarm alerted staff and they followed him outside toward the gate. [Client A] also saw [client C] walking toward the gate and pulled his arm, causing [client C] to fall onto his backside. [Client A] continued to pull [client C] back on the sidewalk, causing a 3inch (sic) by 3 inch abrasion on his backside. Staff redirected [client A] to let go and provided basic first aid to [client C]. Staff gently cleaned the abrasion with soap and water, then applied antibiotic ointment and a bandage over the area. Staff completed an accident incident report and contacted On-Call and the Residential Nurse... [Client C] has a BSP (Behavior Support Plan) that addresses elopement. The group home is equipped with HRC (Human Rights Committee) approved window and door alarms. [Client A] has a BSP that includes physical aggression and attempting to interfere with other consumers during behaviors. [Client C] has a falling risk plan in place due to his poor balance. All staff are trained on BSPs, Risk Plans, and First Aid before working with Consumers." -8/11/15 "On 8/11/2015 at 4:20pm Residential house manager (staff #1) received a phone call from the		immediately. An Inter-disciplinaryTeam (IDT) meeting will be held to discuss the elopement and to create a preventativeplan. All staff working in the home will be trained on all revised plans. Recordsof training will be completed following trainings and submitted to theResidential Director for administrative oversight (Appendix F).	

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	Residential Group Home Nurse that [client C] had eloped from the group home and was on the corner of [name of street] and [name of street] without staff. The Residential House Nurse stopped and got [client C] into her personal vehicle and took him for a drive. Residential House Manager informed the Residential Director at 4:29pm. Residential Director immediately suspended the direct support professionals on shift at the time of the elopement incident, pending investigation. [Client C] has no injuries or mental trauma due to this incident. Initial findings is (sic) that [client C] was out of the home for no more than 3-5 minutes...." Client C's record was reviewed on 10/20/15 at 11:33 AM. Client C's Behavior Problem Records (BPRs) indicated when client C demonstrated "Runs/Wanders Off," staff were to mark an "O." Client C's BPRs indicated the following (not all inclusive): -January 2015 Zero incidents of "Runs/Wanders Off." -February 2015 Zero incidents of "Run/Wanders Off." -March 2015 Client C "Ran/Wander Off"			

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	at 5:00 PM, 6:00 PM and 7:00 PM. On 3/16/15 client C wandered off at 6:00 PM. Client C demonstrated the behavior a total of 4 times in March. No additional documentation and/or notations were made in regard to the incidents. -April 2015 Client C wandered off at 8:00 PM on 4/5/15 and at 4:00 PM on 4/21/15. No additional documentation and/or notations were made in regard to the incidents. -May 2015 Client C wandered off at 5:00 PM on 5/11/15. Client C also wandered off on 5/18/15 at 4:00 PM, 5:00 PM and 6:00 PM. No additional documentation and/or notations were made in regard to the incidents. -June 2015 Client C wandered off on 6/23/15 at 4:00 PM and on 6/30/15 at 6:00 PM. No additional documentation and/or notations were made in regard to the incidents. -July 2015 Client C wandered off on 7/4/15 at 2:00 PM and at 7:00 PM. Client C wandered off on 7/18/15 at 4:00 PM, 5:00 PM, 6:00 PM and at 7:00 PM. Client C wandered off on 7/20/15 at 5:00 PM, 6:00 PM and at 7:00 PM. Client C wandered off on 7/23/15 at 6:00 PM.			

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	Client C wandered off on 7/25/15 at 9:00 AM, 6:00 PM and 8:00 PM. Client C wandered off on 7/26/15 at 10:00 AM, 11:00 AM, 12 noon, 3:00 PM, 4:00 PM, 5:00 PM, 6:00 PM and 7:00 PM. The July 2015 BPR indicated client C also wandered off on 7/27/15 at 9:00 PM. Client C wandered off for a total of 28 times in July 2015. No additional documentation and/or notations were made in regard to the incidents. -August 2015 Client C wandered off on 8/9/15 at 5:00 PM and 6:00 PM. Client C wandered off on 8/10/15 at 4:00 PM, on 8/20/15 at 5:00 PM and 6:00 PM. Client C wandered off on 8/30/15 at 11:00 AM, 12 noon, 2:00 PM and 4:00 PM. The facility did not document client C's elopement from the group home on 8/11/15 (allegedly 2 incidents at the group home and 1 incident at the workshop). Client C eloped for a total of 12 times. No additional documentation and/or notations were made in regard to the incidents. -September 2015 Client C wandered off on 9/1/15 at 8:00 AM. Client C wandered off on 9/9/15 at 5:00 PM, 6:00 PM and 7:00 PM. Client C wandered off on 9/13/15 at 6:00 PM and 7:00 PM. Client C wandered off on 9/23/15 at 4:00 PM. Client C wandered off for a total of			

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	6 times in September 2015. No additional documentation and/or notations were made in regard to the incidents. Client C's July 2015 BSP indicated "... [Client C] is to always have 2 on 1 staffing (2 staff to 1 client in community). He is never to be out in the community or at home with just 1 staff...." The BSP indicated demonstrated elopement behavior which was defined as "Evading staff supervision or the leaving area of the group home or workshop without permission or prior knowledge of staff (sic)...There are door alarms on all exterior doors at the group home. Direct support professionals will ensure the door alarms are on at all times and in proper working order. If they are not working appropriately on call will be notified immediately. [Client C] attempts to evade staff supervision on a daily basis. He attempts to elope from day programming multiple times throughout the day...Residential staff will complete 15 minute checks to document his whereabouts...." Client C's 15 Minute Safety Checks/sheets were reviewed on 10/19/15 at 6:00 PM. Client C's 15 minute checks indicated the facility failed to document 15 minute checks on			

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	10/18/15 from 12:00 PM to 11:45 PM as the 15 minute checklist was blank. Client C's 10/19/15 15 minute check list indicated no 15 minute checks were completed and/or documented from 12:00 AM to 5:48 PM when client C left with 3 staff and 6 other clients to go to a social club at the local mental health department. Interview with staff #7 on 10/19/15 at 6:15 PM indicated client C had a history of elopement. Staff #7 indicated client C had eloped from the group home in the past 2 weeks. Staff #7 stated "The other day he took off real far. I had to run after him." Staff #7 indicated client C was sitting in the front room with other clients and staff #7. Staff #7 indicated client C was not upset when the client got and left the living room. Staff #7 indicated he heard the front door alarm and got up and went to the door to see client C running down the street. Staff #7 indicated client C did not go his usual route as the client went down a different way. Staff #7 indicated client C was in line of sight but he was not near the client as the client was running and he was trying to catch up to the client. Staff #7 indicated client C stopped running when the client did not appear to know where he was at and the client returned to the group home with staff #7. When asked if this incident			

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NAME OF PROVIDER OR SUPPLIER BONA VISTA PROGRAMS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 112 E WESTMORELAND KOKOMO, IN 46901	

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	was reported, staff #7 indicated it was not reported to the administration because client #7 was not out of his line of sight. Staff #7 did indicate he was not near the client. Staff #7 indicated client C was on 15 minute checks. Interview with staff #1 on 10/19/15 at 7:00 PM indicated when shown the blank 15 minute checks staff #1 indicated facility staff did not need to document every 15 minutes. Staff #1 stated facility needed to document 15 minute checks "every 2 hours." Interview with administrative staff #2 and the QIDP on 10/20/15 at 12:50 PM indicated they were not aware of any recent incident where client C eloped from the group home. Administrative staff #2 and the QIDP indicated client C would go to the corner and watch the cars go by. Administrative staff #2 indicated client C would not go far from the group home. Administrative staff #2 and the QIDP indicated client C was to be in line of sight of staff when he eloped and facility staff did not have to report incidents of elopement where the client was in line of sight. When asked if facility staff should have documented/reported the recent incident where staff had to run after client C as the staff was not near the client,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G802	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/30/2015
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	administrative staff #2 stated "Yes." The QIDP indicated facility staff documented data in regard to run/wanders off. The QIDP indicated there was no documentation on what occurred with the incidents and/or how far the client was ahead of the staff even if the client was in line of sight of staff. Administrative staff #2 and the QIDP indicated being in line of sight of staff did not mean client C was near staff. When asked how facility staff were to monitor the client, administrative staff #2 and the QIDP stated the facility staff were to know where client C was located "at all times" in the group home. The QIDP and the administrative staff also indicated 15 minutes were to be completed by the facility staff. The QIDP indicated facility staff was to document the checks every 2 hours. Administrative staff #2 indicated 15 minute checks were to be done every 15 minutes as indicated. This federal tag relates to complaint #IN00180355. 9-3-4(a)			