

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G412	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/23/2015
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12110 BECKLEY DR CUMBERLAND, IN 46229
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W 0000 Bldg. 00	<p>This visit was for the investigation of complaint #IN00175799 which resulted in an Immediate Jeopardy.</p> <p>Complaint #IN00175799: Substantiated, federal and state deficiencies related to the allegation(s) are cited at: W102, W104, W122, W149, W159, W189 and W240.</p> <p>Dates of survey: 6/16/15, 6/17/15, 6/18/15, 6/19/15, 6/22/15 and 6/23/15.</p> <p>Facility Number: 000926 Provider Number: 15G412 AIMS Number: 100244470</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0102 Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to</p>	W 0102	The following has been implemented and is monitored to address the Condition of Participation: Governing Body. An agency administrator completed an	07/23/2015

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

TITLE

(X6) DATE

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

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	<p>exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of client A and to ensure the QIDP integrated, coordinated and monitored client A's active treatment program by failing to convene client A's IST (Individual Support Team) to address the group home's door alarm system not functioning, to ensure staff working with client A were competently and effectively implementing client A's BSP (Behavior Support Plan) and to ensure client A's BSP/ISP (Individual Support Plan) described client A's cell phone usage protocol.</p> <p>The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility met the Condition of Participation: Client Protections. The governing body failed to ensure the facility implemented its policy and procedures to prevent neglect of client A.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of client A</p>		<p>investigation regarding the cited incident. This investigation had the same findings as this report. The QIDP was placed on investigativesuspension pending completion of the investigation. The QIDP was going to be given disciplinary action for her failure to address the fact that the alarms were working properly and to ensure the behavior program was being implemented properly. She did not return to work in the facility prior to leaving employment with no notice, she is no longer employed for the agency. The administrator is the acting QIDP for the facility at this time until another QIDP is trained for the home. Three direct care staff that were working in the home at the time the client left the home unsupervised were also suspended pending completion of the investigation. They all did receive disciplinary action for their failure to ensure the client remained supervised when there was report that she may be planning to leave. Copies of the associated disciplinary actions are attached for review. The facility administration immediately increased the amount of professional presence in the home to ensure the safety of client A when she returned to the home on 6/17/15 and for all clients in the home. It was also addressed with the QIDP and Behavior Consultant that the Behavior Development Program (BDP) that was in place at</p>	

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	<p>and to ensure the QIDP integrated, coordinated and monitored client A's active treatment program by failing to convene client A's IST to address the group home's door alarm system not functioning, to ensure staff working with client A were competently and effectively implementing client A's BSP and to ensure client A's BSP/ISP described client A's cell phone usage protocol. Please see W104.</p> <p>2. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility met the Condition of Participation: Client Protections. The governing body failed to ensure the facility implemented its policy and procedures to prevent neglect of client A. Please see W122.</p> <p>This federal tag relates to complaint #IN00175799.</p> <p>9-3-1(a)</p>		<p>the time of the incident did not adequately describe client A's cell phone usage protocol. As of 6/23/15 client A was discharged from the grouphome, she is living with family and has been approved to receive services from another program (CIH Waiver). All agency QIDP's will receive retraining on their responsibility to ensure that behavior development programs are being implemented properly and that this includes the assurance that all needed systems (i.e. alarms) and resources needed to implement the program are available and functioning properly. The QIDP's will be trained on how to properly address with the IST and/or administration when needed systems and/or resources are not working properly to ensure BDP implementation. The QIDP's will also be trained on how to critique submitted behavior programs for review to ensure the steps included do accurately meet the needs of the client and are clear and reasonable for the direct care staff to implement. Any proposed program that includes a right restriction, such as phone access, will be presented to the IST by the QIDP with their feedback. The administrator participates in the IST and will ensure this review occurs and that the program appropriately meets the needs and depicts how any approved restriction shall be implemented before it is</p>	

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			<p>approved for HRC review and subsequent implementation. The agency training program for new QIDP's will be updated to incorporate the specific training that is being provided to current QIDP's as noted in this plan of correction. The administrator will review all current programs in the home to ensure they adequately meet the current needs of the clients in the home and are clear in describing how each component shall be implemented. This review will be reported to the IST, including the behavior consultant. Should any revisions be needed, the behavior consultant will complete those. The direct care staff in the home are receiving retraining on all behavior programs to ensure their understanding of how to properly implement each plan. They are also being trained to be sure to report when they do not have what is needed to implement a behavior program and to use the agencies chain of command as needed to ensure safety of clients and staff. Professional and administrative staff also have an increased presence in the home to ensure the programs are being implemented as required and to ensure all needed systems and/or resources are available and functioning to ensure proper implementation. The behavior consultant will also have an increased presence in the home to ensure effectiveness and appropriate</p>	

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			<p>implementation of all behavior programs in the facility. All observations in the home will be documented and submitted to the administrator for review. The amount of professional presence will continue at an increased level until otherwise directed by the administrator. The agency will continue to ensure routine professional and administrative presence in the facility on-going. At this time there are not alarms in use in the home as the needs of the current clients do not require this need. In those homes within the agency where door alarms are used, the functioning of these alarms is recorded by staff at each shift. Agency staff will receive retraining to ensure they know their responsibility to check the functioning of alarms and/or other systems in place to ensure safety and to immediately report if an alarm is not functioning properly. Professional staff are in each facility within the agency no less than weekly. During these visits, the professional staff will ensure any alarms or other systems of this nature used to ensure safety are functioning as required. Anytime it is reported that a system is not function properly the administrator will be notified and will provide direction to ensure safety of all clients.</p> <p>Responsible Party: Area Director</p>	

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W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (A), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of client A and to ensure the QIDP integrated, coordinated and monitored client A's active treatment program by failing to convene client A's IST (Individual Support Team) to address the group home's door alarm system not functioning, to ensure staff working with client A were competently and effectively implementing client A's BSP (Behavior Support Plan) and to ensure client A's BSP/ISP (Individual Support Plan) had specific interventions regarding client A's cell phone usage.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of client A. Please see W149.</p>	W 0104	<p>An agency administrator completed an investigation regarding the cited incident. This investigation had the same findings as this report. The QIDP was placed on investigative suspension pending completion of the investigation. The QIDP was going to be given disciplinary action for her failure to address the fact that the alarms were working properly and to ensure the behavior program was being implemented properly. She did not return to work in the facility prior to leaving employment with no notice, she is no longer employed for the agency. The administrator is the acting QIDP for the facility at this time until another QIDP is trained for the home. Three direct care staff that were working in the home at the time the client left the home unsupervised were also suspended pending completion of the investigation. They all did receive disciplinary action for their failure to ensure the client remained supervised when there was report that she may be planning to leave. Copies of the associated disciplinary actions are attached for review. The facility administration immediately increased the amount of professional presence in the home</p>	07/23/2015

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	<p>2. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the QIDP integrated, coordinated and monitored client A's active treatment program by failing to convene client A's IST to address the group home's door alarm system not functioning, to ensure staff working with client A were competently and effectively implementing client A's BSP and to ensure client A's BSP/ISP had specific interventions regarding client A's cell phone usage. Please see W159.</p> <p>3. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure staff working with client A were competently and effectively implementing client A's BSP. Please see W189.</p> <p>4. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure client A's BSP/ISP (Individual Support Plan) had specific interventions regarding client A's cell phone usage. Please see W240.</p> <p>This federal tag relates to complaint #IN00175799.</p>		<p>to ensure the safety of client A when she returned to the home on 6/17/15 and for all clients in the home. It was also addressed with the QIDP and Behavior Consultant that the Behavior Development Program (BDP) that was in place at the time of the incident did not adequately describe client A's cell phone usage protocol. As of 6/23/15 client A was discharged from the group home, she is living with family and has been approved to receive services from another program (CIH Waiver). All agency QIDP's will receive retraining on their responsibility to ensure that behavior development programs are being implemented properly and that this includes the assurance that all needed systems (i.e. alarms) and resources needed to implement the program are available and functioning properly. The QIDP's will be trained on how to properly address with the IST and/or administration when needed systems and/or resources are not working properly to ensure BDP implementation. The QIDP's will also be trained on how to critique submitted behavior programs for review to ensure the steps included do accurately meet the needs of the client and are clear and reasonable for the direct care staff to implement. Any proposed program that includes a right restriction, such as phone access, will be presented to the IST by the QIDP with their</p>	

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	9-3-1(a)		feedback. The administrator participates in the IST and will ensure this review occurs and that the program appropriately meets the needs and depicts how any approved restriction shall be implemented before it is approved for HRC review and subsequent implementation. The agency training program for new QIDP's will be updated to incorporate the specific training that is being provided to current QIDP's as noted in this plan of correction. The administrator will review all current programs in the home to ensure they adequately meet the current needs of the clients in the home and are clear in describing how each component shall be implemented. This review will be reported to the IST, including the behavior consultant. Should any revisions be needed, the behavior consultant will complete those. The direct care staff in the home are receiving retraining on all behavior programs to ensure their understanding of how to properly implement each plan. They are also being trained to be sure to report when they do not have what is needed to implement a behavior program and to use the agencies chain of command as needed to ensure safety of clients and staff. Professional and administrative staff also have an increased presence in the home to ensure the programs are being implemented as required	

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			<p>and to ensure all needed systems and/or resources are available and functioning to ensure proper implementation. The behavior consultant will also have an increased presence in the home to ensure effectiveness and appropriate implementation of all behavior programs in the facility. All observations in the home will be documented and submitted to the administrator for review. The amount of professional presence will continue at an increased level until otherwise directed by the administrator. The agency will continue to ensure routine professional and administrative presence in the facility on-going. At this time there are not alarms in use in the home as the needs of the current clients do not require this need. In those homes within the agency where door alarms are used, the functioning of these alarms is recorded by staff at each shift. Agency staff will receive retraining to ensure they know their responsibility to check the functioning of alarms and/or other systems in place to ensure safety and to immediately report if an alarm is not functioning properly. Professional staff are in each facility within the agency no less than weekly. During these visits, the professional staff will ensure any alarms or other systems of this nature used to ensure safety are functioning as required. Anytime it is</p>	

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W 0122 Bldg. 00	<p>483.420 CLIENT PROTECTIONS</p> <p>The facility must ensure that specific client protections requirements are met. Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 1 of 4 sampled clients (A). The facility failed to implement its policy and procedures to prevent neglect of client A in regard to client A's elopement from the group home with an unidentified male.</p> <p>This noncompliance resulted in an Immediate Jeopardy. The Immediate Jeopardy began on 6/15/15. The Immediate Jeopardy was identified on 6/17/15 at 9:52 AM. The Program Quality Coordinator (PQC) was notified of the Immediate Jeopardy on 6/17/15 at 9:52 AM regarding the facility's failure to ensure client A's cell phone monitoring and supervision protocols were implemented.</p> <p>On 6/22/15 at 2:18 PM, the facility submitted the following plan of action to remove the jeopardy:</p>	W 0122	<p>reported that a system is notfunction properly the administrator will be notified and will provide directionto ensure safety of all clients. Responsible Party: Area Director</p> <p>The following has been implemented and is monitored toaddress the Condition of Client Protections. An agency administrator completedan investigation regarding the cited incident. This investigation had the samefindings as this report. The QIDP was placed on investigative suspensionpending completion of the investigation. The QIDP was going to be givendisciplinary action for her failure to address the fact that the alarms wereworking properly and to ensure the behavior program was being implementedproperly. She did not return to work in the facility prior to leavingemployment with no notice, she is no longer employed for the agency. Theadministrator is the acting QIDP for the facility at this time until anotherQIDP is trained for the home. Threedirect care staff that were working in the home at the time the client left thehome unsupervised were also suspended pending completion of the investigation.They all did receive</p>	07/23/2015

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	"The following details our agency's Plan for Removal of Immediate Jeopardy that was implemented at our facility at [address] in [city and state]. [Client A] was located in [county and state] on 6/17/15 at the home of [male]. The police facilitated her return to [agency]. At the request of the agency, the police removed her cell phone from her possession when she returned to the [city] police department. She was also transported to a local hospital for a full sexual assault exam and treatment. She did acknowledge that she had intercourse with [male]. [Client A] was also tested for sexually transmitted diseases and pregnancy. She was administered emergency contraceptive. This was also directed and approved by the guardian. A psychiatric evaluation was also completed. [Agency] administrative staff asked for an inpatient evaluation. The hospital professionals did not determine this was needed. She was returned to the group home where she was immediately placed on one on one supervision with no access to a cell phone or Internet. Her phone use is restricted. A copy of this protocol was provided to [surveyor]. The IST (Individual Support Team) for [client A] met on 6/18/15. The BDDS (Bureau of Developmental Disabilities Services) coordinator was in attendance. It was		disciplinary action for their failure to ensure the client remained supervised when there was report that she may be planning to leave. Copies of the associated disciplinary actions are attached for review. The facility administration immediately increased the amount of professional presence in the home to ensure the safety of client A when she returned to the home on 6/17/15 and for all clients in the home. It was also addressed with the QIDP and Behavior Consultant that the Behavior Development Program (BDP) that was in place at the time of the incident did not adequately describe client A's cell phone usage protocol. As of 6/23/15 client A was discharged from the group home, she is living with family and has been approved to receive services from another program (CIH Waiver). All agency QIDP's will receive retraining on their responsibility to ensure that behavior development programs are being implemented properly and that this includes the assurance that all needed systems (i.e. alarms) and resources needed to implement the program are available and functioning properly. The QIDP's will be trained on how to properly address with the IST and/or administration when needed systems and/or resources are not working properly to ensure BDP implementation. The QIDP's will also be trained on how to	

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	determined by the team at this meeting that [client A's] ongoing placement at the [group home] is not appropriate. The BDDS service coordinator facilitated an application for an emergency CIH (Community Integration and Habitation) waiver. The protocol to ensure [client A's] ongoing safety was reviewed and updated during this meeting. A copy of the IST note and updated protocol was provided to [surveyor] on 6/18/15. It is also attached to this plan. On 6/22/15, the guardian was notified that [client A] has been approved for the CIH waiver. It was also communicated that this service could be initiated within a week. The legal guardian is working with BDDS to expedite this transition. The IST also convened on 6/22/15 to review the current status. A copy of this note is attached for review. The associated investigation has been completed and submitted to [surveyor] for review. The recommendations are being implemented with oversight of the PQC. Since [client A's] return to the group home, there has been professional presence in the home each day to monitor the implementation and effectiveness of the current protocol to ensure [client A's] safety. This does include inspecting the door alarms in the home to ensure they are working properly and to inspect her bedroom for any devices that she may use to access the		critiquesubmitted behavior programs for review to ensure the steps included doaccurately meet the needs of the client and are clear and reasonable for thedirect care staff to implement. Any proposed program that includes a rightrestriction, such as phone access, will be presented to the IST by the QIDPwith their feedback. The administrator participates in the IST and will ensurethis review occurs and that the program appropriately meets the needs anddepicts how any approved restriction shall be implemented before it is approvedfor HRC review and subsequent implementation. The agency training program fornew QIDP's will be updated to incorporate the specific training that is beingprovided to current QIDP's as noted in this plan of correction. The administrator will review all currentprograms in the home to ensure they adequately meet the current needs of theclients in the home and are clear in describing how each component shall beimplemented. This review will be reported to the IST, including the behaviorconsultant. Should any revisions be needed, the behavior consultant willcomplete those. The direct care staff in the home are receiving retraining onall behavior programs to ensure their understanding of how to properlyimplement each plan. They are also being trained to be sure to	

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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12110 BECKLEY DR CUMBERLAND, IN 46229
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	<p>Internet or to place unapproved phone calls. These observations are documented with specific items requiring review. Those notes since 6/19/15 are attached for review. The agency continues to ensure there is daily professional presence in the home to monitor until [client A] moves out of the group home. The staff working one on one with [client A] are completing a detailed record of what she is doing each 15 minutes. They also record phone calls. The documentation for 6/18/15, 6/19/15 and 6/20/15 is attached for review. At this time with the measures that are in place, the agency feels that we have implemented the needed steps to reduce the risk to [client A] and her housemates. These measures will remain in effect until [client A] moves from our facility. The risk will be removed when she is discharged from the facility. There are no other residents in the home who are risk (sic) for leaving the home in this manner."</p> <p>On 6/23/15 at 2:30 PM, the facility submitted the following addendum to the 6/22/15 Plan of Removal of Immediate Jeopardy: "The following details our agency's addendum to the Plan for Removal of Immediate Jeopardy that was implemented at our facility at [address]. Please refer to the plan submitted on</p>		<p>report when they do have not what is needed to implement a behavior program and to use the agencies chain of command as needed to ensure safety of clients and staff. Professional and administrative staff also have an increased presence in the home to ensure the programs are being implemented as required and to ensure all needed systems and/or resources are available and functioning to ensure proper implementation. The behavior consultant will also have an increased presence in the home to ensure effectiveness and appropriate implementation of all behavior programs in the facility. All observations in the home will be documented and submitted to the administrator for review. The amount of professional presence will continue at an increased level until otherwise directed by the administrator. The agency will continue to ensure routine professional and administrative presence in the facility on-going. At this time there are not alarms in use in the home as the needs of the current clients do not require this need. In those homes within the agency where door alarms are used, the functioning of these alarms is recorded by staff at each shift. Agency staff will receive retraining to ensure they know their responsibility to check the functioning of alarms and/or other systems in place to ensure</p>	

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	<p>6/22/15. [Client A] has been approved for the CIH waiver per conversation with [BDDS service coordinator] from the BDDS office on 6/23/15. The legal guardian has given the directive to discharge [client A] to her mother's home. In conversation with [BDDS service coordinator] I have confirmed that we can act on the directive of the guardian to discharge [client A]. She will receive services under the CIH waiver in the family home. This discharge will occur no later than 6/24/15."</p> <p>The immediate jeopardy was removed on 6/23/15 at 2:35 PM when through observations, interviews and record reviews, it was determined that the facility had implemented the plan of action to remove the immediate jeopardy and that the steps taken removed the immediacy of the problem. Through monitoring observations held on 6/18/15 from 6:40 AM through 7:43 AM, 6/19/15 from 6:40 AM through 7:45 AM, on 6/22/15 from 11:50 AM through 12:39 PM and on 6/23/15 from 1:05 PM through 1:45 PM client A's one to one supervision, phone restrictions and door alarms were observed in place. Record review of staff's one on one documentation, phone monitoring log and administrative observation logs indicated the facility had implemented its</p>		<p>safety and to immediately report if an alarm is notfunctioning properly. Professional staff are in each facility within the agencyno less than weekly. During these visits, the professional staff will ensureany alarms or other systems of this nature used to ensure safety are functioningas required. Anytime it is reported that a system is not function properly theadministrator will be notified and will provide direction to ensure safety ofall clients.</p> <p>Responsible Party: Area Director</p>				

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W 0149 Bldg. 00	<p>plan of removal. Client A was discharged from the home on 6/24/15. Even though the facility's corrective action removed the immediate jeopardy, the facility remained out of compliance at a Condition level due to the facility's need to sustain demonstrative implementation of their plan of correction over a period of time.</p> <p>Findings include:</p> <p>The facility failed to implement its policy and procedures to prevent neglect of client A in regard to client A's elopement from the group home with an unidentified male. Please see W149.</p> <p>This federal tag relates to complaint #IN00175799.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 1 of 4 sampled clients (A), the facility failed to implement its policy and procedures to prevent neglect of client A in regard to client A's elopement from the group home with an unidentified</p>			W 0149	<p>An agency administrator completed an investigation regarding the cited incident. This investigation had the same findings as this report. The QIDP was placed on investigative suspension pending completion of the investigation. The QIDP was</p>		07/23/2015

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	<p>male.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 6/17/15 at 1:46 PM. The review indicated the following:</p> <p>-BDDS report dated 6/16/15 indicated, "On 6/15/15, it was discovered that [client A] had vacated from the group home where she lives. It was presumed that she had arranged to vacate with a friend of hers and had contacted him to come to the home and pick her up. Upon discovering that [client A] was gone from the home, the police were contacted immediately and a missing person report was filed. The missing person report was circulated state wide. The sheriff's department in the [county] and the police department in [city] were also contacted to contact known acquaintances of [client A] to determine if she was with either of these individuals. Either contacts or attempts to contact these acquaintances came up unsuccessful. [Client A's] guardian was contacted to determine her knowledge of the situation and she indicated that she was unaware of [client A's] whereabouts. [Client A's] guardian was contacted and a 'silver alert' was</p>		<p>going to be given disciplinary action for her failure to address the fact that the alarms were working properly and to ensure the behavior program was being implemented properly. She did not return to work in the facility prior to leaving employment with no notice, she is no longer employed for the agency. The administrator is the acting QIDP for the facility at this time until another QIDP is trained for the home. Three direct care staff that were working in the home at the time the client left the home unsupervised were also suspended pending completion of the investigation. They all did receive disciplinary action for their failure to ensure the client remained supervised when there was report that she may be planning to leave. Copies of the associated disciplinary actions are attached for review. The facility administration immediately increased the amount of professional presence in the home to ensure the safety of client A when she returned to the home on 6/17/15 and for all clients in the home. It was also addressed with the QIDP and Behavior Consultant that the Behavior Development Program (BDP) that was in place at the time of the incident did not adequately describe client A's cell phone usage protocol. As of 6/23/15 client A was discharged from the group home, she is living with family and has been</p>	

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	<p>submitted to the police department for circulation throughout the state. At the time of this report, the Silver Alert has not been circulated, but it is anticipated to be circulated shortly. [Client A] has communicated through text messages with employees of [agency] and indicates she is safe, she will not, however, reveal her location."</p> <p>Client A's record was reviewed on 6/16/15 at 4:33 PM. Client A's ISP (Individual Support Plan) dated 6/11/15 indicated, "Prior to moving to [current group home], [client A] was living at the [group home] where she had an incident of elopement where she met up with some people she met on [social media]. [Client A] was brought back home by the police later the next morning." Client A's ISP dated 6/11/15 indicated, "[Client A] has a history of lying, self-mutilation, fighting, impulsivity, arguing with others, bossing others and inappropriate sexual behavior." Client A's 6/11/15 ISP indicated client A had a legal guardian. Client A's ISP dated 6/11/15 indicated, "[Client A] requires 24 hour supervision. [Client A] will not leave the supervision of [agency] without prior IST (Individual Support Team) approval."</p> <p>Client A's IST meeting form dated 5/8/14 indicated, "On 5/7/14 [client A] eloped</p>		<p>approved to receive services from another program (CIH Waiver). All agency QIDP's will receive retraining on their responsibility to ensure that behavior development programs are being implemented properly and that this includes the assurance that all needed systems (i.e. alarms) and resources needed to implement the program are available and functioning properly. The QIDP's will be trained on how to properly address with the IST and/or administration when needed systems and/or resources are not working properly to ensure BDP implementation. The QIDP's will also be trained on how to critique submitted behavior programs for review to ensure the steps included do accurately meet the needs of the client and are clear and reasonable for the direct care staff to implement. Any proposed program that includes a right restriction, such as phone access, will be presented to the IST by the QIDP with their feedback. The administrator participates in the IST and will ensure this review occurs and that the program appropriately meets the needs and depicts how any approved restriction shall be implemented before it is approved for HRC review and subsequent implementation. The agency training program for new QIDP's will be updated to incorporate this specific training that is being provided to current QIDP's</p>	

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	<p>from the [group home] with a man and a woman she had befriended. [Client A] was gone from 10:30 PM through 7:00 AM on 5/8/14. The police and [agency] staff were involved in the search. [Client A] was found by the police walking along the side of [interstate] with the two individuals."</p> <p>Client A's Behavior Development Program (BDP) dated May 2015 indicated client A's targeted problem behaviors included but were not limited to Inappropriate Social Behavior defined as "Interactions with others that may include telling others what to do, ignoring others when directly spoken to (this includes continuing to use/play on her phone when being spoken to), slapping others on the bottom, pinching/tickling others. Also includes using electronic devices inappropriately." Client A's BDP dated May 2015 indicated vacating was defined as "Leaving her assigned area or the house without permission/supervision (as needed) and/or failing to follow sign-out procedures."</p> <p>Client A's BDP dated May 2015 indicated, "Cell Phone Monitoring: Component reviewed May 2015. Staff can check [client A's] cell phone messages at any time, during any shift.</p>		<p>as noted in this plan of correction. The administrator will review all current programs in the home to ensure they adequately meet the current needs of the clients in the home and are clear in describing how each component shall be implemented. This review will be reported to the IST, including the behavior consultant. Should any revisions be needed, the behavior consultant will complete those. The direct care staff in the home are receiving retraining on all behavior programs to ensure their understanding of how to properly implement each plan. They are also being trained to be sure to report when they do have not what is needed to implement a behavior program and to use the agencies chain of command as needed to ensure safety of clients and staff. Professional and administrative staff also have an increased presence in the home to ensure the programs are being implemented as required and to ensure all needed systems and/or resources are available and functioning to ensure proper implementation. The behavior consultant will also have an increased presence in the home to ensure effectiveness and appropriate implementation of all behavior programs in the facility. All observations in the home will be documented and submitted to the administrator for review. The</p>	

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	<p>[Client A] will provide access to all login and password information to staff. If staff discovers, at any time, that [client A] has created a new account without providing them with the login and password information this may result in the loss of the cell phone use and will be determined by her IST. [Client A's] RD (Residential Director) will monitor her [social media] pages/ other social media sites to ensure that she is utilizing these sites appropriately.</p> <p>Login and password information will be stored in [client A's] section of the house program book. [Client A] and staff must sign off when her cell phone messages have been checked on the log in section of the house program book indicating that no inappropriate messages were found. Staff may check text messages, voicemails, pictures and any social media sites.</p> <p>If at any time inappropriate messages/pictures or other material are found on [client A's] cell phone or social media sites staff will immediately notify the RD or RD on-call and her IST will determine what steps are to follow."</p> <p>Client A's BDP dated May 2015 indicated, "Component 7: Staff Supervision and House Alarms. Component Reviewed: May 2015. Alarms have been installed on all exterior</p>		<p>amount of professional presence will continue at an increased level until otherwise directed by the administrator. The agency will continue to ensure routine professional and administrative presence in the facility on-going. At this time there are not alarms in use in the home as the needs of the current clients do not require this need. In those homes within the agency where door alarms are used, the functioning of these alarms is recorded by staff at each shift. Agency staff will receive retraining to ensure they know their responsibility to check the functioning of alarms and/or other systems in place to ensure safety and to immediately report if an alarm is not functioning properly. Professional staff are in each facility within the agency no less than weekly. During these visits, the professional staff will ensure any alarms or other systems of this nature used to ensure safety are functioning as required. Anytime it is reported that a system is not function properly the administrator will be notified and will provide direction to ensure safety of all clients.</p> <p>Responsible Party: Area Director</p>	

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	<p>doors and [client A's] window. Staff must check to ensure all alarms are functioning at the beginning of their shift and record it on the Alarm Monitoring Button found under the Behavior Button in Care Tracker (electronic charting system). If an alarm is not working, staff are to notify the RD or RD- on-call immediately. Staff should have eyes on [client A] at any time she is not inside the group home. This includes the yard, house porches or any public areas." Client A's BDP dated May 2015 indicated, "If any person(s) comes on to the group home property, whom staff do not recognize and the person cannot identify themselves as someone who should be there (i.e. Department of Health Surveyor) the staff are to immediately ensure all consumers are in the home, all doors/windows are locked and to call the police. After calling the police, staff should call the RD/RD on-call."</p> <p>Staff #1 was interviewed on 6/16/15 at 4:00 PM. Staff #1 stated, "[Client A] was on the phone a lot this weekend. While I was braiding her hair [client A] had her cell phone down on the table. I was able to notice she was having a conversation with a guy. She talks to several guys on [social media]. The conversation was about him coming to get her. I</p>			

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	<p>documented a little something about it in the phone monitoring log. Nothing else happened that night. She stayed in her room most of the night, she was very into her phone. On the phone constantly. Didn't want to eat or take her medications. This was on Sunday (6/14/15)." When asked if she had reported client A's 6/14/15 conversation about a male coming to pick her up, staff #1 stated, "No, I wasn't aware of the procedure. The next day, [staff #3] told [RD #1] about the phone, about picking her up."</p> <p>When asked to describe the events of her shift at the group home on 6/15/15 leading up to client A's elopement, staff #1 stated, "I was inside in the living room. The other staff, [staff #2 and #3] were outside. [Staff #2] and [staff #3] were out front (front yard of house). [Client A] had taken a blanket, a backpack and few items out to the front yard. [Client C] was out front too and was telling staff that the guy was circling the neighborhood. We saw a truck. We watched it drive past the house." Staff #1 stated, "[Client C] came in and reported that [client A] was gone. We didn't hear an alarm (door alarm). Everyone started looking for her. We called the RD and the police." When asked if she had reported the suspicious vehicle to the RD or police prior to client A's elopement,</p>			

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	<p>staff #1 stated, "No, we talked about it. Asked [staff #4] about it but it seemed like she was going to call." Staff #1 indicated the door alarms were not working on 6/15/15.</p> <p>Staff #2's written statement dated 6/15/15 was reviewed on 6/17/15 at 4:38 PM. Staff #2's written statement indicated, "I came in at 5:00 PM. When I came in, I started help(ing) [staff #4] cook dinner. [Client A] and [client C] went outside and [staff #4] went out with them. Then [staff #4] came back in a (sic) [staff #3] went out with [client A] and [client C] until they came in for dinner. [Client A] didn't want to do her chores, she didn't feel good and she wasn't hungry. I fixed [client A] a plate anyway and she went in her room talking on the phone. Dinner was about 6:00 PM. I helped the consumers with their chores, [client A] refused to do her chore which was clean the table. After dinner and chores [client A] was still in her room. [Staff #3] said [client A] was talking on the phone to a guy (and) asked (if) the guy was in front of the house. So right away [staff #3], [staff #1] and [staff #2] went outside to watch for whoever was suppose (sic) to be riding pass (sic) the house. Staff say (sic) a Black truck ride pass (sic) they were looking straight ahead, this was about 7:30 PM. The car didn't ride pass</p>			

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	<p>(sic) again while staff was out there. We were out there until about 8:00 PM. The door by the kitchen was lock (sic) we didn't see the car ride pass (sic) anymore. I don't know how [client A] left. It was plan (sic), I really believe that this been plan (sic)."</p> <p>Staff #2 was interviewed on 6/16/15 at 4:54 PM. Staff #2 indicated the RD and/or the police were not notified of the suspicious vehicle driving past the group home. Staff #2 stated, "The door alarms haven't worked for about 2 months. The RD knows about it."</p> <p>Staff #3's written statement dated 6/15/15 was reviewed on 6/17/15 at 4:22 PM. Staff #3's written statement dated 6/15/15 indicated, "About 5:10 [client C] and [client A] had informed staff that they were heading outside with a blanket to sit. [Staff #4] followed them outdoors." Staff #3's written statement dated 6/15/15 indicated, "During this time I am unsure what had transpired outside but it sounded like an issue with [clients A and C], so I headed outdoors. When I went outside [client A] didn't speak to me when I was speaking to her and [client C]. The girls were sitting in the front yard on the blanket. I remained outside with the girls for about 45 minutes or so until it was time for dinner and both girls had</p>			

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	<p>returned to the house. [Client A] refused dinner. The evening continued as normal with chores and the assistance of staff (sic). [Client A] did not do her chore either. About 7:50 PM or so [client A] came walking through the front area of the home with her cell phone. Myself, [staff #3], [staff #1] and [staff #2] overheard [client A] on the phone while standing in the front door, state to the person on the phone that she was standing in the door and that she still didn't see him. I asked [client A] who is she having drive by the house. [Client A] stated no one and returned to her room....</p> <p>[Client C] came outside and began pouring out all this information of [client A's] plans to leave us three staff." Staff #3's written statement dated 6/15/15 indicated, "[Client C] informed us that [client A] and the person who was driving by had planned to have her out of the house by 8:05 PM or 8:10 PM." Staff #3's written statement dated 6/15/15 indicated, "Somewhere between this time [client A] snuck out the home before it was her turn for medications."</p> <p>Staff #3's written statement dated 6/16/15 was reviewed on 6/17/15 at 4:30 PM. Staff #3's written statement dated 6/16/15 indicated, "The alarms when I arrived to [group home] where (sic) not in proper working condition. On 6/15/15 I also do</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G412	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/23/2015
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12110 BECKLEY DR CUMBERLAND, IN 46229
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	<p>not recall the alarms going off the time prior to 6/15/15 or on 6/12/15, the [RD #1] was present when I arrived on this day."</p> <p>RD #2's (on-call RD on 6/15/15) written statement dated 6/15/15 was reviewed on 6/17/15 at 5:00 PM. RD #2's written statement dated 6/15/15 indicated, "On 6/15/15 at 8:41 PM, I received a call from [staff #1] at [group home] saying that [client A] vacated the home. [Client A] ran out the door and got in the truck with some guy and pulled off. [Staff #1] said she was about to call the police." RD #2's 6/15/15 written statement indicated, "[Staff #1] also mentioned that she was sitting outside with the consumers and a car kept riding past but the driver in the car never made eye contact, he just looked straight ahead."</p> <p>RD #1's written statement dated 6/16/15 regarding client A's 6/15/15 incident was reviewed on 6/17/15 at 5:35 PM. RD #1's written statement dated 6/16/15 indicated, "I came to [group home] to let a staff into the home. Once I arrived another staff was already there to open the door. The staff began to tell me about various consumer behaviors from the night before. [Staff #1] then told me that while doing [client A's] hair on Friday 6/12/15 she noticed that [client A] was</p>			

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	<p>talking to (a) male through texting and was saying some vulgar statements. [Staff #1] then stated that she would not be surprised if [client A] did not plan to have someone meet her at the house after transport and leave with him."</p> <p>RD #1 was interviewed on 6/16/15 at 7:25 PM. RD #1 indicated staff #1 reported client A's 6/12/15 text messages on 3:15 PM on 6/15/15 upon RD #1's arrival at the group home.</p> <p>Client A's cell phone monitoring log was reviewed on 6/17/15 at 5:30 PM. Client A's 6/14/15 entry indicated, "Trying to get guys to pick up." The review indicated documentation of cell phone monitoring occurring on 2/2/15 and 6/14/15. The review did not indicate additional documentation of cell phone monitoring.</p> <p>Client C was interviewed on 6/17/15 at 8:18 AM. Client C stated, "[Client A] told me not to tell anyone about her leaving. She was talking to boys to come get her. [Client A's] boyfriend offered me \$300.00 not to tell anyone about the plan. I told [staff #1] that [client A] was going to leave. I told [staff #5] but he told everyone not to believe me." Client C stated, "[Client A] kept turning the alarms off."</p>			

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	<p>Observations were conducted at the group home on 6/16/15 from 6:45 PM through 7:40 PM and on 6/17/15 from 7:30 AM through 7:45 AM. The alarms on both exterior doors in the home were not functioning throughout the observation periods.</p> <p>AS (Administrative Staff #1 was interviewed on 6/16/15 at 5:18 PM. AS #1 indicated the facility's Abuse and Neglect policy should be implemented. AS #1 indicated staff #1 should have reported client A's 6/12/15 conversation to the RD or RD on-call. AS #1 indicated staff #1, #2 and/or #3 should have reported the suspicious vehicle to the police and the RD on-call to prevent client A vacating the home with the unknown male. AS #1 indicated client A's cell phone should be monitored and inappropriate messages or pictures should be reported to the RD. AS #1 indicated client A's BDP should be implemented. AS #1 indicated staff should ensure the door alarms are functioning at the beginning of each shift and issues reported to the RD. AS #1 indicated the RD should notify the IST of ongoing issues with the door alarms to determine alternate options to ensure client A's monitoring. AS #1 indicated client A was assessed as needing 24 hour supervision</p>			

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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12110 BECKLEY DR CUMBERLAND, IN 46229
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W 0159 Bldg. 00	<p>and was considered at risk while in the community with an unknown male.</p> <p>The facility's policy and procedures were reviewed on 6/17/15 at 6:20 PM. The facility's Preventing Abuse and Neglect policy dated 10/2013 indicated, "DSA, incorporated prohibits abuse, neglect, exploitation, mistreatment or violation of the rights of the consumers it serves." The facility's Preventing Abuse and Neglect policy dated 10/2013 indicated, "Neglect means failure to provide supervision, training, appropriate care... to an individual."</p> <p>This federal tag relates to complaint #IN00175799.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 1 of 4 sampled clients (A), the QIDP (Qualified Intellectual Disabilities Professional) failed to integrate, coordinate and monitor client A's active treatment program by failing to convene client A's IST (Individual Support Team)</p>	W 0159	An agency administrator completed an investigation regarding the cited incident. This investigation had the same findings as this report. The QIDP was placed on investigative suspension pending completion of the investigation. The QIDP was going to be given disciplinary action for her failure to address the fact	07/23/2015

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	<p>to address the group home's door alarm system not functioning and client A's failure to comply with her cell phone monitoring protocol, to ensure staff working with client A were competently and effectively implementing client A's BSP (Behavior Support Plan) and to ensure client A's BSP/ISP (Individual Support Plan) had specific interventions regarding client A's cell phone usage.</p> <p>Findings include:</p> <p>1. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 6/17/15 at 1:46 PM. The review indicated the following:</p> <p>-BDDS report dated 6/16/15 indicated, "On 6/15/15, it was discovered that [client A] had vacated from the group home where she lives. It was presumed that she had arranged to vacate with a friend of hers and had contacted him to come to the home and pick her up. Upon discovering that [client A] was gone from the home, the police were contacted immediately and a missing person report was filed. The missing person report was circulated state wide. The sheriff's department in the [county] and the police department in [city] were also contacted to contact known acquaintances of [client</p>		<p>that the alarms were working properly and to ensure the behavior program was being implemented properly. She did not return to work in the facility prior to leaving employment with no notice, she is no longer employed for the agency. The administrator is the acting QIDP for the facility at this time until another QIDP is trained for the home. The facility administration immediately increased the amount of professional presence in the home to ensure the safety of client A when she returned to the home on 6/17/15 and for all clients in the home. It was also addressed with the QIDP and Behavior Consultant that the Behavior Development Program (BDP) that was in place at the time of the incident did not adequately describe client A's cell phone usage protocol. As of 6/23/15 client A was discharged from the group home, she is living with family and has been approved to receive services from another program (CIH Waiver). All agency QIDP's will receive retraining on their responsibility to ensure that behavior development programs are being implemented properly and that this includes the assurance that all needed systems (i.e. alarms) and resources needed to implement the program are available and functioning properly. The QIDP's will be trained on how to properly address with the IST and/or administration when needed</p>	

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	<p>A] to determine if she was with either of these individuals. Either contacts or attempts to contact these acquaintances came up unsuccessful. [Client A's] guardian was contacted to determine her knowledge of the situation and she indicated that she was unaware of [client A's] whereabouts. [Client A's] guardian was contacted and a 'silver alert' was submitted to the police department for circulation throughout the state. At the time of this report, the Silver Alert has not been circulated, but it is anticipated to be circulated shortly. [Client A] has communicated through text messages with employees of [agency] and indicates she is safe, she will not, however, reveal her location."</p> <p>Investigation Summary Form dated 6/19/15 indicated the following:</p> <p>-"Administrative Review of Client A's incident on 6/15/15. (5.) The RD (Residential Director)/QIDP is an inexperienced QIDP who has been managing a difficult situation with conflicting directives being given by the guardian and the IST (Individual Support Team)."</p> <p>-"Findings: (1.) The RD/QIDP was aware that the alarms were not working properly on a consistent basis. She had</p>		<p>systems and/or resources are not working properly to ensure BDP implementation. The QIDP's will also be trained on how to critique submitted behavior programs for review to ensure the steps included do accurately meet the needs of the client and are clear and reasonable for the direct care staff to implement. Any proposed program that includes a right restriction, such as phone access, will be presented to the IST by the QIDP with their feedback. The administrator participates in the IST and will ensure this review occurs and that the program appropriately meets the needs and depicts how any approved restriction shall be implemented before it is approved for HRC review and subsequent implementation. The agency training program for new QIDP's will be updated to incorporate this specific training that is being provided to current QIDP's as noted in this plan of correction. The administrator will review all current programs in the home to ensure they adequately meet the current needs of the clients in the home and are clear in describing how each component shall be implemented. This review will be reported to the IST, including the behavior consultant. Should any revisions be needed, the behavior consultant will complete those. The direct care staff in the home are receiving retraining on all behavior</p>	

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	<p>not addressed the issue to ensure they are working properly; (2.) The RD/QIDP was made aware of staff concern on 6/15/15 that [client A] may be planning to leave with a guy. [RD/QIDP] reports that she reminded staff of [client A's] history and the need to monitor her closely. She noticed that there were not batteries in the alarm. She left the home before addressing this."</p> <p>Client A's record was reviewed on 6/16/15 at 4:33 PM. Client A's BDP dated May 2015 indicated, "Cell Phone Monitoring: Component reviewed May 2015. Staff can check [client A's] cell phone messages at any time, during any shift. [Client A] will provide access to all login and password information to staff. If staff discovers, at any time, that [client A] has created a new account without providing them with the login and password information this may result in the loss of the cell phone use and will be determined by her IST. [Client A's] RD (Residential Director) will monitor her [social media] pages/ other social media sites to ensure that she is utilizing these sites appropriately. Login and password information will be stored in [client A's] section of the house program book. [Client A] and staff must sign off when her cell phone messages have been checked on the log in section of the house</p>		<p>programsto ensure their understanding of how to properly implement each plan. They arealso being trained to be sure to report when they do have not what is needed toimplement a behavior program and to use the agencies chain of command as neededto ensure safety of clients and staff. Professional (including QIDPs) and administrative staff also have anincreased presence in the home to ensure the programs are being implemented asrequired and to ensure all needed systems and/or resources are available andfunctioning to ensure proper implementation. All observations in the home willbe documented and submitted to the administrator for review. The amount ofprofessional presence will continue at an increased level until otherwisedirected by the administrator. The agency will continue to ensure routineprofessional and administrative presence in the facility on-going. At this timethere are not alarms in use in the home as the needs of the current clients donot require this need. In those homes within the agency where door alarms areused, the functioning of these alarms is recorded by staff at each shift. Professional staff are in each facility within the agency no less than weekly. During these visits, the professional staff will ensure any</p>	

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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 12110 BECKLEY DR CUMBERLAND, IN 46229		
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	<p>program book indicating that no inappropriate messages were found. Staff may check text messages, voicemails, pictures and any social media sites. If at any time inappropriate messages/pictures or other material are found on [client A's] cell phone or social media sites staff will immediately notify the RD or RD on-call and her IST will determine what steps are to follow."</p> <p>Client A's BDP dated May 2015 indicated, "Component 7: Staff Supervision and House Alarms. Component Reviewed: May 2015. Alarms have been installed on all exterior doors and [client A's] window. Staff must check to ensure all alarms are functioning at the beginning of their shift and record it on the Alarm Monitoring Button found under the Behavior Button in Care Tracker (electronic charting system). If an alarm is not working, staff are to notify the RD or RD- on-call immediately. Staff should have eyes on [client A] at any time she is not inside the group home. This includes the yard, house porches or any public areas." Client A's BDP dated May 2015 indicated, "If any person(s) comes on to the group home property, whom staff do not recognize and the person cannot identify themselves as someone who should be there (i.e. Department of</p>		<p>alarms or othersystems of this nature used to ensure safety are functioning as required.Anytime it is reported that a system is not function properly the administratorwill be notified and will provide direction to ensure safety of all clients.</p> <p>Responsible Party: Area Director</p>		

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	<p>Health Surveyor) the staff are to immediately ensure all consumers are in the home, all doors/windows are locked and to call the police. After calling the police, staff should call the RD/RD on-call."</p> <p>Staff #1 was interviewed on 6/16/15 at 4:00 PM. Staff #1 stated, "[Client A] was on the phone a lot this weekend. While I was braiding her hair [client A] had her cell phone down on the table. I was able to notice she was having a conversation with a guy. She talks to several guys on [social media]. The conversation was about him coming to get her. I documented a little something about it in the phone monitoring log. Nothing else happened that night. She stayed in her room most of the night, she was very into her phone. On the phone constantly. Didn't want to eat or take her medications. This was on Sunday (6/14/15)." When asked if she had reported client A's 6/14/15 conversation about a male coming to pick her up, staff #1 stated, "No, I wasn't aware of the procedure. The next day, [staff #3] told [RD #1] about the phone, about picking her up."</p> <p>Staff #2 was interviewed on 6/16/15 at 4:54 PM. Staff #2 stated, "The door alarms haven't worked for about 2</p>			

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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12110 BECKLEY DR CUMBERLAND, IN 46229
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	<p>months. The RD knows about it."</p> <p>Staff #3's written statement dated 6/16/15 was reviewed on 6/17/15 at 4:30 PM. Staff #3's written statement dated 6/16/15 indicated, "The alarms when I arrived to [group home] where (sic) not in proper working condition. On 6/15/15 I also do not recall the alarms going off the time prior to 6/15/15 or on 6/12/15 the [RD #1] was present when I arrived on this day."</p> <p>RD #1's written statement dated 6/16/15 regarding client A's 6/15/15 incident was reviewed on 6/17/15 at 5:35 PM. RD #1's written statement dated 6/16/15 indicated, "I came to [group home] to let a staff into the home. Once I arrived another staff was already there to open the door. The staff began to tell me about various consumer behaviors from the night before. [Staff #1] then told me that while doing [client A's] hair on Friday 6/12/15 she noticed that [client A] was talking to (a) male through texting and was saying some vulgar statements. [Staff #1] then stated that she would not be surprised if [client A] did not plan to have someone meet her at the house after transport and leave with him."</p> <p>RD #1 was interviewed on 6/16/15 at 7:25 PM. RD #1 indicated staff #1</p>			

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W 0189 Bldg. 00	<p>reported client A's 6/12/15 text messages on 3:15 PM on 6/15/15 upon RD #1's arrival at the group home.</p> <p>AS (Administrative Staff) #1 was interviewed on 6/16/15 at 5:18 PM. AS #1 indicated the RD/QIDP should have notified the IST of ongoing issues with the door alarms.</p> <p>2. The QIDP failed to integrate, coordinate and monitor client A's active treatment program by failing to ensure staff working with client A were competently and effectively implementing client A's BSP. Please see W189.</p> <p>3. The QIDP failed to integrate, coordinate and monitor client A's active treatment program by failing to ensure client A's BSP/ISP had specific interventions regarding client A's cell phone usage protocol. Please see W240.</p> <p>This federal tag relates to complaint #IN00175799.</p> <p>9-3-3(a)</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that</p>			

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	<p>enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview for 1 of 4 sampled clients (A), the facility failed to ensure staff working with client A were competently and effectively implementing client A's BSP (Behavior Support Plan).</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 6/17/15 at 1:46 PM. The review indicated the following:</p> <p>-BDDS report dated 6/16/15 indicated, "On 6/15/15, it was discovered that [client A] had vacated from the group home where she lives. It was presumed that she had arranged to vacate with a friend of hers and had contacted him to come to the home and pick her up. Upon discovering that [client A] was gone from the home, the police were contacted immediately and a missing person report was filed. The missing person report was circulated state wide. The sheriff's department in the [county] and the police department in [city] were also contacted to contact known acquaintances of [client A] to determine if she was with either of</p>	W 0189	<p>An agency administrator completed an investigation regarding the cited incident. This investigation had the same findings as this report. The QIDP was placed on investigative suspension pending completion of the investigation. The QIDP was going to be given disciplinary action for her failure to address the fact that the alarms were working properly and to ensure the behavior program was being implemented properly. She did not return to work in the facility prior to leaving employment with no notice, she is no longer employed for the agency. The administrator is the acting QIDP for the facility at this time until another QIDP is trained for the home. The facility administration immediately increased the amount of professional presence in the home to ensure the safety of client A when she returned to the home on 6/17/15 and for all clients in the home. It was also addressed with the QIDP and Behavior Consultant that the Behavior Development Program (BDP) that was in place at the time of the incident did not adequately describe client A's cell phone usage protocol. As of 6/23/15 client A was discharged from the group home, she is living with family and has been approved to receive services from another program (CIH Waiver). All agency QIDP's will</p>	07/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G412	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/23/2015
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12110 BECKLEY DR CUMBERLAND, IN 46229
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	<p>these individuals. Either contacts or attempts to contact these acquaintances came up unsuccessful. [Client A's] guardian was contacted to determine her knowledge of the situation and she indicated that she was unaware of [client A's] whereabouts. [Client A's] guardian was contacted and a 'silver alert' was submitted to the police department for circulation throughout the state. At the time of this report, the Silver Alert has not been circulated, but it is anticipated to be circulated shortly. [Client A] has communicated through text messages with employees of [agency] and indicates she is safe, she will not, however, reveal her location."</p> <p>Investigation Summary Form dated 6/19/15 indicated the following:</p> <p>-"Administrative Review of Client A's incident on 6/15/15. (5.) The RD (Residential Director)/QIDP (Qualified Intellectual Disabilities Professional) is an inexperienced QIDP who has been managing a difficult situation with conflicting directives being given by the guardian and the IST (Individual Support Team)."</p> <p>-"Findings: (1.) The RD/QIDP was aware that the alarms were not working properly on a consistent basis. She had</p>		<p>receive retraining on their responsibility to ensure that behavior development programs are being implemented properly and that this includes the assurance that all needed systems (i.e. alarms) and resources needed to implement the program are available and functioning properly. This does include the responsibility to ensure that direct care staff are properly trained to implement behavior programs as written and that this training requires a competency assessment. The QIDP must provide evidence of completed training to the Area Director for review and to approve any new employee working alone with clients in the facility. The direct care staff in the home are receiving retraining on all behavior programs to ensure their understanding of how to properly implement each plan. They are also being trained to be sure to report when they do not have what is needed to implement a behavior program and to use the agencies chain of command as needed to ensure safety of clients and staff. Professional (including QIDPs) and administrative staff also have an increased presence in the home to ensure the programs are being implemented as required and to provide additional staff training as needed. All observations in the home will be documented and submitted to the administrator for review. The amount of</p>	

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	<p>not addressed the issue to ensure they are working properly; (2.) The RD/QIDP was made aware of staff concern on 6/15/15 that [client A] may be planning to leave with a guy. [RD/QIDP] reports that she reminded staff of [client A's] history and the need to monitor her closely. She noticed that there were not batteries in the alarm. She left the home before addressing this."</p> <p>-"Findings regarding the responsibility of the staff who were present in the home when the incident occurred: (1.) Five direct support staff were onsite and working when [client A] left the home at about 8:40 PM on 6/15/15.... (6.) The three staff in the living area that were not administering medications all acknowledged that proper monitoring of [client A] was not maintained given the concerns they had about what had been going on before she did leave. They all communicated responsibility in this incident and showed clear upset that this happened and concern for [client A's] safety.... All staff reported that they all work with all consumers and don't exclusively work with the consumers they were assigned to. This job list system was not being implemented per policy. No staff could identify who was responsible for supervising [client A]. They report that they all work with all the</p>		<p>professional presence will continue at an increased level until otherwise directed by the administrator. The agency will continue to ensure routine professional and administrative presence in the facility on-going. When any observation determines there is a need for additional staff training, the administrator will ensure this occurs. Responsible Party: Area Director</p>	

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	<p>consumers."</p> <p>Client A's record was reviewed on 6/16/15 at 4:33 PM. Client A's ISP (Individual Support Plan) dated 6/11/15 indicated, "Prior to moving to [current group home], [client A] was living at the [group home] where she had an incident of elopement where she met up with some people she met on [social media]. [Client A] was brought back home by the police later the next morning." Client A's ISP dated 6/11/15 indicated, "[Client A] has a history of lying, self-mutilation, fighting, impulsivity, arguing with others, bossing others and inappropriate sexual behavior."</p> <p>Client A's IST meeting form dated 5/8/14 indicated, "On 5/7/14 [client A] eloped from the [group home] with a man and a woman she had befriended. [Client A] was gone from 10:30 PM through 7:00 AM on 5/8/14. The police and [agency] staff were involved in the search. [Client A] was found by the police walking along the side of [interstate] with the two individuals."</p> <p>Client A's BDP dated May 2015 indicated, "Cell Phone Monitoring: Component reviewed May 2015. Staff can check [client A's] cell phone messages at any time, during any shift.</p>			

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	<p>[Client A] will provide access to all login and password information to staff. If staff discovers, at any time, that [client A] has created a new account without providing them with the login and password information this may result in the loss of the cell phone use and will be determined by her IST. [Client A's] RD (Residential Director) will monitor her [social media] pages/ other social media sites to ensure that she is utilizing these sites appropriately. Login and password information will be stored in [client A's] section of the house program book. [Client A] and staff must sign off when her cell phone messages have been checked on the log in section of the house program book indicating that no inappropriate messages were found. Staff may check text messages, voicemails, pictures and any social media sites. If at any time inappropriate messages/pictures or other material are found on [client A's] cell phone or social media sites staff will immediately notify the RD or RD on-call and her IST will determine what steps are to follow."</p> <p>Client A's BDP dated May 2015 indicated, "Component 7: Staff Supervision and House Alarms. Component Reviewed: May 2015. Alarms have been installed on all exterior doors and [client A's] window. Staff must</p>			

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	<p>check to ensure all alarms are functioning at the beginning of their shift and record it on the Alarm Monitoring Button found under the Behavior Button in Care Tracker (electronic charting system). If an alarm is not working, staff are to notify the RD or RD- on-call immediately. Staff should have eyes on [client A] at any time she is not inside the group home. This includes the yard, house porches or any public areas." Client A's BDP dated May 2015 indicated, "If any person(s) comes on to the group home property, whom staff do not recognize and the person cannot identify themselves as someone who should be there (i.e. Department of Health Surveyor) the staff are to immediately ensure all consumers are in the home, all doors/windows are locked and to call the police. After calling the police, staff should call the RD/RD on-call."</p> <p>Staff #1 was interviewed on 6/16/15 at 4:00 PM. Staff #1 stated, "[Client A] was on the phone a lot this weekend. While I was braiding her hair [client A] had her cell phone down on the table. I was able to notice she was having a conversation with a guy. She talks to several guys on [social media]. The conversation was about him coming to get her. I documented a little something about it in</p>			

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	<p>the phone monitoring log. Nothing else happened that night. She stayed in her room most of the night, she was very into her phone. On the phone constantly. Didn't want to eat or take her medications. This was on Sunday (6/14/15)." When asked if she had reported client A's 6/14/15 conversation about a male coming to pick her up, staff #1 stated, "No, I wasn't aware of the procedure. The next day, [staff #3] told [RD #1] about the phone, about picking her up."</p> <p>When asked to describe the events of her shift at the group home on 6/15/15 leading up to client A's elopement, staff #1 stated, "I was inside in the living room. The other staff, [staff #2 and #3] were outside. [Staff #2] and [staff #3] were out front (front yard of house). [Client A] had taken a blanket, a backpack and few items out to the front yard. [Client C] was out front too and was telling staff that the guy was circling the neighborhood. We saw a truck. We watched it drive past the house." Staff #1 stated, "[Client C] came in and reported that [client A] was gone. We didn't hear an alarm (door alarm). Everyone started looking for her. We called the RD and the police." When asked if she had reported the suspicious vehicle to the RD or police prior to client A's elopement, staff #1 stated, "No, we talked about it.</p>			

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	<p>Asked [staff #4] about it but it seemed like she was going to call." Staff #1 indicated the door alarms were not working on 6/15/15.</p> <p>Staff #2's written statement dated 6/15/15 was reviewed on 6/17/15 at 4:38 PM. Staff #2's written statement indicated, "I came in at 5:00 PM when I came in, I started help(ing) [staff #4] cook dinner. [Client A] and [client C] went outside and [staff #4] went out with them. Then [staff #4] came back in a (sic) [staff #3] went out with [client A] and [client C] until they came in for dinner. [Client A] didn't want to do her chores, she didn't feel good and she wasn't hungry. I fixed [client A] a plate anyway and she went in her room talking on the phone. Dinner was about 6:00 PM. I helped the consumers with their chores, [client A] refused to do her chore which was clean the table. After dinner and chores [client A] was still in her room. [Staff #3] said [client A] was talking on the phone to a guy (and) asked (if) the guy was in front of the house. So right away [staff #3], [staff #1] and [staff #2] went outside to watch for whoever was suppose to be riding pass (sic) the house. Staff say (sic) a Black truck ride pass (sic) they were looking straight ahead, this was about 7:30 PM. The car didn't ride pass (sic) again while staff was out there. We were</p>			
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	<p>out there until about 8:00 PM. The door by the kitchen was lock (sic) we didn't see the car ride pass (sic) anymore. I don't know how [client A] left. It was plan (sic), I really believe that this been plan (sic)."</p> <p>Staff #2 was interviewed on 6/16/15 at 4:54 PM. Staff #2 indicated the RD and/or the police were not notified of the suspicious vehicle driving past the group home. Staff #2 stated, "The door alarms haven't worked for about 2 months. The RD knows about it."</p> <p>Staff #3's written statement dated 6/15/15 was reviewed on 6/17/15 at 4:22 PM. Staff #3's written statement dated 6/15/15 indicated, "About 5:10 [client C] and [client A] had informed staff that they were heading outside with a blanket to sit. [Staff #4] followed them outdoors." Staff #3's written statement dated 6/15/15 indicated, "During this time I am unsure what had transpired outside but it sounded like an issue with [clients A and C], so I headed outdoors. When I went outside [client A] didn't speak to me when I was speaking to her and [client C]. The girls were sitting in the front yard on the blanket. I remained outside with the girls for about 45 minutes or so until it was time for dinner and both girls had returned to the house. [Client A] refused</p>			

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	<p>dinner. The evening continued as normal with chores and the assistance of staff (sic). [Client A] did not do her chore either. About 7:50 PM or so [client A] came walking through the front area of the home with her cell phone. Myself, [staff #3], [staff #1] and [staff #2] overheard [client A] on the phone while standing in the front door, state to the person on the phone that she was standing in the door and that she still didn't see him. I asked [client A] who is she having drive by the house. [Client A] stated no one and returned to her room.... [Client C] came outside and began pouring out all this information of [client A's] plans to leave us three staff." Staff #3's written statement dated 6/15/15 indicated, "[Client C] informed us that [client A] and the person who was driving by had planned to have her out of the house by 8:05 PM or 8:10 PM." Staff #3's written statement dated 6/15/15 indicated, "Somewhere between this time [client A] snuck out the home before it was her turn for medications."</p> <p>Staff #3's written statement dated 6/16/15 was reviewed on 6/17/15 at 4:30 PM. Staff #3's written statement dated 6/16/15 indicated, "The alarms when I arrived to [group home] where (sic) not in proper working condition. On 6/15/15 I also do not recall the alarms going off the time</p>			

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	<p>prior to 6/15/15 on 6/12/15 the [RD #1] was present when I arrived on this day."</p> <p>RD #1's written statement dated 6/16/15 regarding client A's 6/15/15 incident was reviewed on 6/17/15 at 5:35 PM. RD #1's written statement dated 6/16/15 indicated, "I came to [group home] to let a staff into the home. Once I arrived another staff was already there to open the door. The staff began to tell me about various consumer behaviors from the night before. [Staff #1] then told me that while doing [client A's] hair on Friday 6/12/15 she noticed that [client A] was talking to (a) male through texting and was saying some vulgar statements. [Staff #1] then stated that she would not be surprised if [client A] did not plan to have someone meet her at the house after transport and leave with him."</p> <p>RD #1 was interviewed on 6/16/15 at 7:25 PM. RD #1 indicated staff #1 reported client A's 6/12/15 text messages on 3:15 PM on 6/15/15 upon RD #1's arrival at the group home.</p> <p>Client A's cell phone monitoring log was reviewed on 6/17/15 at 5:30 PM. Client A's 6/14/15 entry indicated, "Trying to get guys to pick up." The review indicated documentation of cell phone monitoring occurring on 2/2/15 and</p>			

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W 0240	<p>6/14/15. The review did not indicate additional documentation of cell phone monitoring.</p> <p>AS (Administrative Staff #1 was interviewed on 6/16/15 at 5:18 PM. AS #1 indicated staff #1 should have reported client #1's 6/12/15 conversation to the RD or RD on-call. AS #1 indicated staff #1, #2 and/or #3 should have reported the suspicious vehicle to the police and the RD on-call to prevent client A vacating the home with the unknown male. AS #1 indicated client A's cell phone should be monitored and inappropriate messages or pictures should be reported to the RD. AS #1 indicated client A's BDP should be implemented. AS #1 indicated staff should ensure the door alarms are functioning at the beginning of each shift and issues reported to the RD. AS #1 indicated the RD should notify the IST of ongoing issues with the door alarms to determine alternate options to ensure client A's monitoring.</p> <p>This federal tag relates to complaint #IN00175799.</p> <p>9-3-3(a)</p> <p>483.440(c)(6)(i)</p>			

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Bldg. 00	<p>INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on record review and interview for 1 of 4 sampled clients (A), the facility failed to ensure client A's BSP (Behavior Development Plan)/ISP (Individual Support Plan) had specific interventions to address client A's cell phone usage.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 6/17/15 at 1:46 PM. The review indicated the following:</p> <p>-BDDS report dated 6/16/15 indicated, "On 6/15/15, it was discovered that [client A] had vacated from the group home where she lives. It was presumed that she had arranged to vacate with a friend of hers and had contacted him to come to the home and pick her up. Upon discovering that [client A] was gone from the home, the police were contacted immediately and a missing person report was filed. The missing person report was circulated state wide. The sheriff's department in the [county] and the police department in [city] were also contacted to contact known acquaintances of [client A] to determine if she was with either of</p>	W 0240	<p>An agency administrator completed an investigation regarding the cited incident. This investigation had the same findings as this report. The QIDP was placed on investigative suspension pending completion of the investigation. She did not return to work in the facility prior to leaving employment with no notice, she is no longer employed for the agency. The administrator is the acting QIDP for the facility at this time until another QIDP is trained for the home. The facility administration immediately increased the amount of professional presence in the home to ensure the safety of client A when she returned to the home on 6/17/15 and for all clients in the home. It was also addressed with the QIDP and Behavior Consultant that the Behavior Development Program (BDP) that was in place at the time of the incident did not adequately describe client A's cellphone usage protocol. As of 6/23/15 client A was discharged from the group home, she is living with family and has been approved to receive services from another program (CIH Waiver). Agency QIDP's will be trained on how to critique submitted behavior programs for review to ensure the steps included do accurately meet the needs of the client and are clear</p>	07/23/2015
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	<p>these individuals. Either contacts or attempts to contact these acquaintances came up unsuccessful. [Client A's] guardian was contacted to determine her knowledge of the situation and she indicated that she was unaware of [client A's] whereabouts. [Client A's] guardian was contacted and a 'silver alert' was submitted to the police department for circulation throughout the state. At the time of this report, the Silver Alert has not been circulated, but it is anticipated to be circulated shortly. [Client A] has communicated through text messages with employees of [agency] and indicates she is safe, she will not, however, reveal her location."</p> <p>Investigation Summary Form dated 6/19/15 indicated the following:</p> <p>-"The [BC (Behavior Consultant)] and IST (Individual Support Team) did not place parameters in place regarding how [client A] could earn back her cell phone privileges. Rather they allowed circumstances to dictate the return of the phone which allowed [client A] to manipulate the situation."</p> <p>-"[IAS (Investigating Administrative Staff)] reviewed the contents of [client A's] chart and made copies of the BDP and pertinent IST notes. This information</p>		<p>and reasonable for the direct care staff to implement. Any proposed program that includes a right restriction, such as phone access, will be presented to the IST by the QIDP with their feedback. The administrator participates in the IST and will ensure this review occurs and that the program appropriately meets the needs and depicts how any approved restriction shall be implemented before it is approved for HRC review and subsequent implementation. The agency training program for new QIDP's will be updated to incorporate the specific training that is being provided to current QIDP's as noted in this plan of correction. The administrator will review all current programs in the home to ensure they adequately meet the current needs of the clients in the home and are clear in describing how each component shall be implemented. This review will be reported to the IST, including the behavior consultant. Should any revisions be needed, the behavior consultant will complete those. Professional (including QIDP's) and administrative staff also have an increased presence in the home to ensure the programs are being implemented as required and are effective. All observations in the home will be documented and submitted to the administrator for review. The amount of professional presence will continue at an</p>	

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	<p>is attached for review. Within this documentation it is not clear what [client A's] access to her phone should be at this time. I, [IAS], met with [RD (Residential Director)/QIDP (Qualified Intellectual Disabilities Professional)], [BC], [AD (Area Director)] and [client A's guardian (by phone)]. It is the understanding of this group that per [client A's] recent BDP update that she has monitored access and use of her phone."</p> <p>"-We also discussed the decisions regarding access to the phone since 5/1/15. There is a 5/1/15 IST note that proposed that the phone should be taken away from [client A]."</p> <p>"-On 5/28/15 another IST meeting was held. At this meeting it was discussed that it was too late to take the phone. It was determined that [client A] be provided a phone that does not have a camera. The issue at this time with the phone use was sending people inappropriate pictures of herself."</p> <p>"-On 6/3/15 at 6:00 PM, the police came to the home following a complaint from [male] that [client A] was placing threatening calls and sending threatening texts to him. The guardian gave the instruction at this time to remove the phone from [client A]."</p>		<p>increased level until otherwisredirected by the administrator. The agency will continue to ensure routineprofessional and administrative presence in the facility on-going Responsible Party: Area Director</p>	

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	<p>- "After the phone was taken, [client A] and her mother called [guardian] at which time her mother threatened [guardian]. At this time [guardian] instructed that the phone be returned but that her use be monitored. There were no clear directives on how to monitor the use."</p> <p>- "[AD] provided me training documentation of training that was done on 6/3/15 regarding [client A's] use of a cell phone and other monitoring. This occurred on 6/3/15 at 9:00 AM. This training is attached. The first item that staff sign says 'I understand that [client A] is not to have access to any cell phone, computers, or tablet where she could access social media such as [social media], email or [social media]. This is not consistent with the applicable portion of the BDP."</p> <p>- "Findings...; (3.) There are inconsistencies in the record regarding what kind of access [client A] has to a cell phone. The BDP dated 5/30/15 indicates that her cell phone use will be monitored. It is signed by the RD on 6/1/15 and then by the guardian on 6/3/15. At 9:00 AM on 6/3/15 there is staff training on the updated BDP. This is conducted by the BC. The training documents indicate [client A] shall not</p>			

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	<p>have access to a phone. This is an inconsistency. The behavior program also does not address how to respond when she will not comply with the cell phone monitoring. This should have been an expectation given her prior reactions when attempts were made to control or monitor the use of the phone."</p> <p>Client A's record was reviewed on 6/16/15 at 4:33 PM. Client A's Behavior Development Program (BDP) dated May 2015 indicated client A's targeted problem behaviors included but were not limited to Inappropriate Social Behavior defined as "Interactions with others that may include telling others what to do, ignoring others when directly spoken to (this includes continuing to use/play on her phone when being spoken to), slapping others on the bottom, pinching/tickling others. Also includes using electronic devices inappropriately."</p> <p>Client A's BDP dated May 2015 indicated, "Cell Phone Monitoring: Component reviewed May 2015. Staff can check [client A's] cell phone messages at any time, during any shift. [Client A] will provide access to all login and password information to staff. If staff discovers, at any time, that [client A] has created a new account without providing them with the login and password</p>			

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	<p>information this may result in the loss of the cell phone use and will be determined by her IST. [Client A's] RD (Residential Director) will monitor her [social media] pages/ other social media sites to ensure that she is utilizing these sites appropriately. Login and password information will be stored in [client A's] section of the house program book. [Client A] and staff must sign off when her cell phone messages have been checked on the log in section of the house program book indicating that no inappropriate messages were found. Staff may check text messages, voicemails, pictures and any social media sites. If at any time inappropriate messages/pictures or other material are found on [client A's] cell phone or social media sites staff will immediately notify the RD or RD on-call and her IST will determine what steps are to follow."</p> <p>Client A's IST note dated 5/1/15 indicated, "[Client A] has been posting nude pictures on social media and sending them to men. [Ex-boyfriend] came into the office on 5/1/15 and showed the pictures from his mobile device. [Client A] has displayed this sort of behavior in the past. [Client A's guardian] has stated that her devices which have Internet access be taken away upon conversation on 5/1/15." The 5/1/15</p>			

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	<p>IST note indicated, "Recommend that [client A's] mobile devices, tablets and ipods be taken away to prevent her from sending further sexually illicit pictures."</p> <p>Client A's IST note dated 5/28/15 indicated the IST discussed and recommended client A be provided with a phone that does not have a camera.</p> <p>AS (Administrative Staff) was interviewed on 6/23/15 at 2:15 PM. AS #1 indicated client A's BDP should have indicated specific interventions to address client A's cell phone use.</p> <p>This federal tag relates to complaint #IN00175799.</p> <p>9-3-4(a)</p>			