

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G794		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/02/2013	
NAME OF PROVIDER OR SUPPLIER AWS				STREET ADDRESS, CITY, STATE, ZIP CODE 9110 N CR 700 W SCIPIO, IN 47273			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000000	<p>This visit was for an investigation of complaint #IN00130955.</p> <p>Complaint #IN00130955: Substantiated. Federal/state deficiencies related to the allegation are cited at W102, W104, W122, W149 and W186.</p> <p>Survey dates: July 1 and 2, 2013.</p> <p>Facility number: 012529 Provider number: 15G794 AIM number: 201017530</p> <p>Surveyor: Dotty Walton, QIDP.</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/11/13 by Ruth Shackelford, QIDP.</p>	W000000					

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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W000102	<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 for 1 of 2 sampled clients (A), the facility failed to meet the Condition of Participation: Governing Body. The Governing Body failed to exercise general operating direction by failing to implement policy/procedure that prohibited staff neglect of client A (failed to prevent client A from swallowing a battery and failed to prevent client A from eloping and lying in a county road, stopping traffic).</p> <p>Findings include:</p> <p>Please refer to W104 for 1 of 2 sampled clients (A), for the Governing Body's failure to exercise general operating direction over the facility by failing to implement policies and procedures which prohibited client neglect in regards to client A swallowing a battery and by failing to prevent client A's eloping and lying in a county road stopping traffic via behavioral interventions (one to one/two to one staffing).</p> <p>Please refer to W122 for the Governing Body's failure to meet the Condition of Participation: Client Protections for 1 of</p>	W000102	<p>W 102</p> <p>Governing Body – did not exercise general operating direction by allowing client to swallow battery and break free from supervision to lie in road, stopping traffic.</p> <p>Corrective action for resident(s) found to have been affected</p> <p><u>Pica</u> – the affected client's BSP will be revised to restrict contact with battery-operated electronics, including remote controls. Staff will be trained on <i>all</i> restrictions in place, including Pica restrictions.</p> <p><u>Supervision</u> – staff will be trained on positioning to prevent exiting doors when client is escalated behaviorally. A fence will also be installed that will not prevent, but will slow exiting toward the road. The fence will expand the area of the facility that is safe for de-escalation, and it will provide staff a salient opportunity to prevent leaving the expanded safe area.</p>	08/01/2013	

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	<p>2 sampled clients (A). The Governing Body failed to ensure the rights of all clients to be free of neglect, by failing to prevent client A's ingestion of a battery and eloping (lying down in a county road stopping traffic) via behavioral interventions and one to one staffing supervision.</p> <p>This federal tag relates to complaint #IN00130955.</p> <p>9-3-1(a)</p>		<p>How facility will identify other residents potentially affected & what measures taken</p> <p>Although this is the only client in the home who engages in these dangerous behaviors presently, all residents potentially will benefit from having an expanded safe area.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence</p> <p>New restriction will be put in place to prevent recurrence of battery swallowing and fence will be installed to increase safe area, which will reduce the opportunity to leave supervision. Also, staff training will occur to prevent recurrence of unsafe conditions cited in the survey.</p> <p>How corrective actions will be monitored to ensure no recurrence</p> <p>The Group Home Manager supervises staff, including ensuring that their training needs are met. The Behavior Clinician (BC) trains staff on BSPs, including restrictive measures in place. The BC monitors</p>		

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			<p>restrictions and reports to the IDT. The IDT oversees the ISP and determines the need for restrictions. Management staff complete home visit forms and will assist in monitoring the implementation of new corrections. The Director supervises management staff and reviews home visit forms at regular meetings. The IDT meets regularly and reviews incidents. The agency's Incident Oversight Committee – comprised of the Director, an agency Vice President, and a Compliance Officer – reviews all incidents. When insufficient corrective action is put in place, the committee follows up with the agency's management staff.</p>		

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W000104	<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 2 of 2 sampled clients (A and B), and 2 additional clients (C and D), the facility's governing body failed to exercise general policy and operating direction over the facility by neglecting to implement its policies and procedures to ensure supervision of the clients during behaviors (lying in the road with on coming traffic and meals (supervising clients at risk for choking). The facility failed to provide sufficient staff to deal with behaviors and supervise clients.</p> <p>Findings include:</p> <p>Observations were conducted at the facility on July 1, 2013 from 4:55 PM until 7:00 PM. Client A was observed to return to the facility from a local hospital overnight stay accompanied by staff #7 and #9. Staff #8 was supervising evening meal preparation and clients B, C, and D at 5:00 PM. Client A became upset at 5:15 PM when she was told she had not earned a soda. Client A's one to one staff #7 called staff #9 for assistance as client A's behavior escalated. Staff #7 and #9 followed client A from her bedroom to the living area beside the back door of the</p>	W000104	<p>W 104</p> <p>Governing Body – failed to supervise sufficiently to prevent client from lying in road and did not supervise clients in danger of choking.</p> <p>Corrective action for resident(s) found to have been affected</p> <p>Multiple steps will be taken to enhance supervision and prevent problems cited in the survey:</p> <p><u>Leaving supervision / lying in road</u> – staff will be trained on positioning to prevent exiting doors when client is escalated behaviorally. A fence will also be installed that will not prevent, but will slow exiting toward the road. The fence will expand the area of the facility that is safe for de-escalation, and it will provide staff a salient opportunity to prevent leaving the safe area.</p> <p><u>Leaving clients unsupervised /</u></p>	08/01/2013			

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	<p>facility. Staff #8 had placed a steaming hot crockpot full of beef, potatoes and mixed vegetables on the dining table for clients B and D. Client C's food (beef, potatoes, onion and mixed vegetables) had been modified to mechanical soft consistency in a food processor and her beverage was a nectar thick consistency. Clients B and D ate a regular consistency diet. Client A ran to the front door and exited the facility at 5:30 PM with staff #7 and #9 in pursuit but unable to stop her. Client A sat in the front yard for a time and ran into the county road in front of the dwelling and laid down at 5:34 PM stretching her body across the road. Staff stood in the road with the client. A car and a small truck heading south stopped in the road. The three clients were at the table eating and steam was visibly rising from the crockpot of beef and vegetables. Staff #8 saw client A and staff #7 and #9 in the road and left the facility to give assistance. The three clients were at the table eating and steam was visibly rising from the crockpot of beef and vegetables when staff left them unattended to help with client A. Staff #8 told clients B, C, and D to be wary of the food on the dining room table because it was "very hot." Staff #8 assisted staff #7 and #9 by carrying client A out of the road onto the front yard. Staff #9 returned to the house to monitor clients B, C, and D. Staff #8</p>		<p><u>choking risk</u> – staff will be trained on need to remain with vulnerable clients with choking risk at all times, even during behavior problems for other client(s). Additionally, there are two nearby high-behavior homes with multiple staff who are cross trained with all clients in this facility – each high-behavior home provides three staff members during waking hours. Both nearby homes will maintain an “on-call” staff person who can assist with emergent issues at this facility. Staff at this facility will receive training to request assistance from one of these staff members if escalation occurs. The assisting staff from the nearby home will provide temporary enhanced supervision for the non-escalated clients (including any clients with choking risk who are eating) while the third staff member working in this facility provides extra help with escalated client.</p> <p>How facility will identify other residents potentially affected & what measures taken</p> <p>If staffing is all pulled to one client who is having problems, all residents in the home are affected. The corrective measures identified here will address the needs of all clients at the facility.</p>		

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	<p>counseled client A as staff #7 assisted as well.</p> <p>At 5:50 PM, staff #7 cut a banana into bite sized (1/2 inch) pieces for client D. Staff #7 indicated client C was on a mechanical soft diet due to being a choking risk and client D's food was cut into bite sized pieces because she had a tendency to eat fast or take bites which were too big to be safe.</p> <p>Interview with staff #9 on 7/1/13 at 6:45 PM indicated clients were to be monitored at mealtimes but it took all 3 staff working to remove client A from the road. The interview indicated two staff were unable to keep the client out of the road despite their best efforts. The interview indicated client A was a one to one staffing ratio during waking hours because of her extreme behaviors.</p> <p>Client A's record was reviewed on 7/1/13 at 5:10 PM and 7/2/13 at 9:45 AM. The review indicated client A was five feet one inch tall and weighed 198.6 pounds as of 6/24/13. The review indicated a 7/1/13 (revision date) Behavior Support Plan/BSP. The BSP indicated the client's diagnoses included, but were not limited to, Chronic Depressive Disorder, Borderline Personality Disorder, Post-Traumatic Stress Disorder, Hydrocephalus, Shunt revision in head,</p>		<p>Measures or systemic changes facility put in place to ensure no recurrence</p> <p>Staff training on positioning, fence installation to increase safe area and slow behavioral elopement, and formalizing assistance from nearby homes will all be put in place to prevent recurrence of cited problems.</p> <p>How corrective actions will be monitored to ensure no recurrence</p> <p>The Group Home Manager supervises staff, including ensuring that their training needs are met. Management staff complete home visit forms and will assist in monitoring the implementation of new corrections. The Director supervises management staff and reviews home visit forms at regular meetings. The IDT meets regularly and reviews incidents. The agency's Incident Oversight Committee – comprised of the Director, an agency Vice President, and a Compliance Officer – reviews all incidents. When insufficient corrective action is put in place, the committee follows up with the agency's management staff.</p>				

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	<p>victim of sexual abuse and victim of Munchausen by proxy. The BSP indicated client A would elope from the premises and would threaten suicide, engage in self injury with intent at self harm (head banging, trying to jump from a height to damage/injure her head) and she had a history of PICA (eating inedible objects).</p> <p>Client C's record was reviewed on 7/1/13 at 6:28 PM and indicated the July 2013 doctor's order for a mechanical soft diet signed by the physician on 6/26/13. The review indicated a dining plan dated 5/27/13 which indicated the client was at risk for "choking (and) aspiration." The dining plan listed client C's diet as "mechanical soft ground meat, rice size pieces, chop all meat in chopper," moisten bread and cookies with milk, substitute pudding for ice cream, nectar thick liquids, "no food in front of her not mechanical soft." "Staff must remain at the table to maintain safety and provide prompts to take small bites, chew food thoroughly."</p> <p>An interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 7/01/13 at 2:15 PM and on 7/02/13 at 5:30 PM. The QIDP indicated client A required multiple staff to intervene because of her suicidal threats and behaviors of aggression, elopement</p>						

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	<p>and PICA. The interview indicated clients were to be supervised at all times and staff should not have left clients with choking risks unsupervised with food (client C).</p> <p>This federal tag relates to complaint #IN00130955.</p> <p>9-3-1(a)</p>			

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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, record review and interview for 1 of 2 sampled clients (A), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to ensure the rights of all clients to be free of neglect, by failing to prevent client A's eloping and lying in a county road stopping traffic via behavioral interventions (one to one/two to one staffing).</p> <p>Findings include:</p> <p>Please refer to W149 for 1 of 2 sampled clients (A), for the facility's failure to implement written policies and procedures which prohibited neglect of clients.</p> <p>Please refer to W186 for the facility's failure to provide sufficient staff for 2 of 2 sampled clients (A and B), and 2 additional clients (C and D). The facility neglected to provide sufficient staff to deal with client A's behaviors and supervise mealtime for clients with choking risks and challenging behavior.</p> <p>This federal tag relates to complaint #IN00130955.</p>	W000122	<p>W 122</p> <p>Client Protections – failed to supervise sufficiently to prevent client from lying in road and did not supervise clients in danger of choking.</p> <p>Corrective action for resident(s) found to have been affected</p> <p>Multiple steps will be taken to enhance supervision and prevent problems cited in the survey:</p> <p><u>Leaving supervision / lying in road</u> – staff will be trained on positioning to prevent exiting doors when client is escalated behaviorally. A fence will also be installed that will not prevent, but will slow exiting toward the road. The fence will expand the area of the facility that is safe for de-escalation, and it will provide staff a salient opportunity to prevent leaving the safe area.</p> <p><u>Leaving clients unsupervised / choking risk</u> – staff will be trained</p>	08/01/2013			

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	9-3-2(a)		<p>on need to remain with vulnerable clients with choking risk at all times, even during behavior problems for other client(s). Additionally, there are two nearby high-behavior homes with multiple staff who are cross trained with all clients in this facility – each high-behavior home provides three staff members during waking hours. Both nearby homes will maintain an “on-call” staff person who can assist with emergent issues at this facility. Staff at this facility will receive training to request assistance from one of these staff members if escalation occurs. The assisting staff from the nearby home will provide temporary enhanced supervision for the non-escalated clients (including any clients with choking risk who are eating) while the third staff member working in this facility provides extra help with escalated client.</p> <p>How facility will identify other residents potentially affected & what measures taken</p> <p>If staffing is all pulled to one client who is having problems, all residents in the home are affected. The corrective measures identified here will address the needs of all clients at the facility.</p>		

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			<p>Measures or systemic changes facility put in place to ensure no recurrence</p> <p>Staff training on positioning, fence installation to increase safe area and slow behavioral elopement, and formalizing assistance from nearby homes will all be put in place to prevent recurrence.</p> <p>How corrective actions will be monitored to ensure no recurrence</p> <p>The Group Home Manager supervises staff, including ensuring that their training needs are met. Management staff complete home visit forms and will assist in monitoring the implementation of new corrections. The Director supervises staff and reviews home visit forms at regular staff meetings. The IDT meets regularly and reviews incidents. The agency's Incident Oversight Committee – comprised of the Director, an agency Vice President, and a Compliance Officer – reviews all incidents. When insufficient corrective action is put in place, the committee follows up with the agency's management staff.</p>		

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W000149	<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 6 of 15 incident/investigative reports reviewed affecting 2 of 2 sampled clients (A and B), and 2 additional clients (C and D), the facility neglected to implement its policies and procedures to ensure supervision of the clients so as to prevent neglect of the clients.</p> <p>Findings include:</p> <p>Observations were conducted at the facility on July 1, 2013 from 4:55 PM until 7:00 PM. Client A was observed to return to the facility from a local hospital overnight stay accompanied by staff #7 and #9. Staff #8 was supervising evening meal preparation and clients B, C, and D at 5:00 PM. Client A became upset at 5:15 PM when she was told she had not earned a soda. Client A's one to one staff #7 called staff #9 for assistance as client A's behavior escalated. Staff #7 and #9 followed client A from her bedroom to the living area beside the back door of the facility. Staff #8 had placed a steaming hot crockpot full of beef, potatoes and mixed vegetables on the dining table for clients B and D. Client C's food (beef,</p>	W000149	<p>W 149</p> <p>Staff Treatment of Clients – providing adequate supervision across multiple incidents.</p> <p>Corrective action for resident(s) found to have been affected</p> <p>Multiple steps will be taken to enhance supervision and prevent problems cited in the survey:</p> <p>-</p> <p><u>Pica</u> – the client's BSP will be revised to restrict contact with battery-operated electronics, including remote controls. Staff will be trained on all restrictions in place, including Pica restrictions.</p> <p><u>Leaving supervision / lying in road</u> – staff will be trained on positioning to prevent exiting doors when client is escalated behaviorally. A fence will also be installed that will not prevent, but will slow exiting toward the road. The fence will expand the area of the facility that is safe for</p>	08/01/2013			

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	<p>potatoes, onion and mixed vegetables) had been modified to mechanical soft consistency in a food processor and her beverage was a nectar thick consistency. Clients B and D ate a regular consistency diet. Client A ran to the front door and exited the facility at 5:30 PM with staff #7 and #9 in pursuit but unable to stop her. Client A sat in the front yard for a time and ran into the county road in front of the dwelling and laid down at 5:34 PM stretching her body across the road. Staff stood in the road with the client. A car and a small truck heading south stopped in the road. The three clients were at the table eating and steam was visibly rising from the crockpot of beef and vegetables. Staff #8 saw client A and staff #7 and #9 in the road and left the facility to give assistance. The three clients were at the table eating and steam was visibly rising from the crockpot of beef and vegetables when staff left them unattended to help with client A. Staff #8 told clients B, C, and D to be wary of the food on the dining room table because it was "very hot." Staff #8 assisted staff #7 and #9 by carrying client A out of the road onto the front yard. Staff #9 returned to the house to monitor clients B, C, and D. Staff #8 counseled client A as staff #7 assisted as well.</p> <p>At 5:50 PM, staff #7 cut a banana into bite sized (1/2 inch) pieces for client D.</p>		<p>de-escalation, and it will provide staff a salient opportunity to prevent leaving the safe area.</p> <p><u>Leaving clients unsupervised / choking risk</u> – staff will be trained on need to remain with vulnerable clients with choking risk at all times, even during behavior problems for other client(s). Additionally, there are two nearby high-behavior homes with multiple staff who are cross trained with all clients in this facility – each high-behavior home provides three staff members during waking hours. Both nearby homes will maintain an “on-call” staff person who can assist with emergent issues at this facility. Staff at this facility will receive training to request assistance from one of these staff members if escalation occurs. The assisting staff from the nearby home will provide temporary enhanced supervision for the non-escalated clients (including any clients with choking risk who are eating) while the third staff member working in this facility provides extra help with escalated client.</p> <p>How facility will identify other residents potentially affected & what measures taken</p>				

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	<p>Staff #7 indicated client C was on a mechanical soft diet due to being a choking risk and client D's food was cut into bite sized pieces because she had a tendency to eat fast or take bites which were too big to be safe.</p> <p>Interview with staff #9 on 7/1/13 at 6:45 PM indicated clients were to be monitored at mealtimes but it took all 3 staff working to remove client A from the road. The interview indicated two staff were unable to keep the client out of the road despite their best efforts. The interview indicated client A was a one to one staffing ratio during waking hours because of her extreme behaviors.</p> <p>Client A's record was reviewed on 7/1/13 at 5:10 PM and 7/2/13 at 9:45 AM. The review indicated client A was five feet one inch tall and weighed 198.6 pounds as of 6/24/13. The review indicated a 7/1/13 (revision date) Behavior Support Plan/BSP. The BSP indicated the client's diagnoses included, but were not limited to, Chronic Depressive Disorder, Borderline Personality Disorder, Post-Traumatic Stress Disorder, Hydrocephalus, Shunt revision in head, victim of sexual abuse and victim of Munchausen by proxy. The BSP indicated client A would elope from the premises and would threaten suicide, engage in self</p>		<p>All residents potentially affected, and corrective measures address the needs of all clients.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence</p> <p>If staffing is all pulled to one client who is having problems, all residents in the home are affected. The corrective measures identified here will address the needs of all clients at the facility.</p> <p>Measures or systemic changes facility put in place to ensure no recurrence</p> <p>Staff training on positioning, fence installation to increase safe area and slow behavioral elopement, and formalizing assistance from nearby homes will all be put in place to prevent recurrence.</p> <p>How corrective actions will be monitored to ensure no recurrence</p> <p>The Group Home Manager supervises staff, including ensuring that their training needs are met. Management staff complete home visit forms and</p>				

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	<p>injury with intent at self harm (head banging, trying to jump from a height to damage/injure her head) and she had a history of PICA (eating inedible objects).</p> <p>Client C's record was reviewed on 7/1/13 at 6:28 PM and indicated the July 2013 doctor's order for a mechanical soft diet signed by the physician on 6/26/13. The review indicated a dining plan dated 5/27/13 which indicated the client was at risk for "choking (and) aspiration." The dining plan listed client C's diet as "mechanical soft ground meat, rice size pieces, chop all meat in chopper," moisten bread and cookies with milk, substitute pudding for ice cream, nectar thick liquids, "no food in front of her not mechanical soft." "Staff must remain at the table to maintain safety and provide prompts to take small bites, chew food thoroughly."</p> <p>A review of the facility's incident/investigative reports was conducted on 7/01/13 at 1:15 PM and indicated the following incidents with client A:</p> <p>1. 6/30/13 6:55 AM, client A took a double A battery from a television remote control and swallowed it. She was taken to a local emergency room and the battery was removed by a scope via her</p>		<p>will assist in monitoring the implementation of new corrections. The Director supervises staff and reviews home visit forms at regular staff meetings. The IDT meets regularly and reviews incidents. The agency's Incident Oversight Committee – comprised of the Director, an agency Vice President, and a Compliance Officer – reviews all incidents. When insufficient corrective action is put in place, the committee follows up with the agency's management staff.</p>				

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	<p>esophagus. Client A was one on one (one staff monitoring her) when the incident happened. Client A was admitted to the hospital and returned to the facility at 5:00 PM on 7/1/13.</p> <p>2. 6/12/13 4:30 PM, client A left the facility (eloped) via the back door and ran into the well traveled county road in front of the facility and laid down in the road with traffic coming from both directions north/south). Staff providing one to one supervision (plus the second staff) were unable to keep her out of the road.</p> <p>3. 6/09/13 4:00 PM, client A went out the backdoor of the facility and used garden mulch to scratch her abdomen.</p> <p>4. 5/31/13 1:40 PM, client A became upset on the van returning from day program and was restrained by staff. Returned to facility but eloped and was brought back in to the facility by staff.</p> <p>5. 4/28/13 5:31 PM, client A eloped from facility and obtained wooden garden mulch to cut self, staff took mulch away.</p> <p>6. 3/27/13 6:30 AM, client A eloped from the facility and staff coaxed client A back onto the property after 25 minutes.</p> <p>A review of the facility's Group Home</p>						

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	<p>Abuse and Neglect policy, dated 12/5/12, was conducted on 7/01/13 at 2:36 PM. The policy indicated, in part, "AWS does not tolerate abuse, neglect or exploitation in any form by any person." The following definitions of abuse, neglect and exploitation are provided. "Alleged, suspected or actual neglect (which must also be reported to Adult Protective Services or Child Protective Services, as indicated), which includes but is not limited to:</p> <ul style="list-style-type: none"> a. failure to provide appropriate supervision, care or training; b. failure to provide a safe, clean and sanitary environment...." <p>The 8/2008 "Group Home Abuse and Neglect" policy was reviewed 7/02/13 at 9:00 AM and indicated..."Neglect includes failure to provide appropriate care, food, medical care or supervision."</p> <p>An interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 7/01/13 at 2:15 PM and on 7/02/13 at 5:30 PM. The QIDP indicated client A was a one to one (staff supervision level) because of her suicidal threats and behaviors of aggression, elopement and PICA. The interview indicated clients were to be supervised at all times and staff should not have left clients with choking risks unsupervised</p>						

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	with food (client C). The interviews indicated the agency prohibits neglect of clients. This federal tag relates to complaint #IN00130955. 9-3-2(a)						

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W000186	<p>483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, record review and interview for 2 of 2 sampled clients (A and B), and 2 additional clients (C and D), the facility neglected to provide sufficient staff to deal with client A's behaviors and supervise mealtime for clients with choking risks and challenging behavior.</p> <p>Findings include:</p> <p>Observations were conducted at the facility on July 1, 2013 from 4:55 PM until 7:00 PM. Client A was observed to return to the facility from a local hospital overnight stay accompanied by staff #7 and #9. Staff #8 was supervising evening meal preparation and clients B, C, and D at 5:00 PM. Client A became upset at 5:15 PM when she was told she had not earned a soda. Client A's one to one staff #7 called staff #9 for assistance as client A's behavior escalated. Staff #7 and #9 followed client A from her bedroom to the living area beside the back door of the</p>	W000186	<p>W 186 Direct Care Staff – There was insufficient staff to address both the problem behavior of eloping client and supervision of other clients during meal time. Corrective action for resident(s) found to have been affected Multiple steps will be taken to enhance supervision and prevent problems cited in the survey: <u>Leaving supervision / lying in road</u> – staff will be trained on positioning to prevent exiting doors when client is escalated behaviorally. A fence will also be installed that will not prevent, but will slow exiting toward the road. The fence will expand the area of the facility that is safe for de-escalation, and it will provide staff a salient opportunity to prevent leaving the safe area. <u>Leaving clients unsupervised / choking risk</u> – staff will be trained on need to remain with vulnerable clients with choking risk at all times, even during behavior problems for other client(s). Additionally, there are two nearby high-behavior homes with multiple staff who are cross</p>	08/01/2013	

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	<p>facility. Staff #8 had placed a steaming hot crockpot full of beef, potatoes and mixed vegetables on the dining table for clients B and D. Client C's food (beef, potatoes, onion and mixed vegetables) had been modified to mechanical soft consistency in a food processor and her beverage was a nectar thick consistency. Clients B and D ate a regular consistency diet. Client A ran to the front door and exited the facility at 5:30 PM with staff #7 and #9 in pursuit but unable to stop her. Client A sat in the front yard for a time and ran into the county road in front of the dwelling and laid down at 5:34 PM stretching her body across the road. Staff stood in the road with the client. A car and a small truck heading south stopped in the road. The three clients were at the table eating and steam was visibly rising from the crockpot of beef and vegetables. Staff #8 saw client A and staff #7 and #9 in the road and left the facility to give assistance. The three clients were at the table eating and steam was visibly rising from the crockpot of beef and vegetables when staff left them unattended to help with client A. Staff #8 told clients B, C, and D to be wary of the food on the dining room table because it was "very hot." Staff #8 assisted staff #7 and #9 by carrying client A out of the road onto the front yard. Staff #9 returned to the house to monitor clients B, C, and D. Staff #8</p>		<p>trained with all clients in this facility – each of these homes provides three staff members during waking hours. Each nearby home will maintain an "on-call" staff person who can assist with emergent issues at this facility. Staff at this facility will receive training to request assistance from one of these staff members if escalation occurs. The assisting staff from the nearby home will provide temporary enhanced supervision for the non-escalated clients (including any with choking risk who are eating) while the third staff member working in this facility provides extra help with escalated client. How facility will identify other residents potentially affected & what measures taken If staffing is all pulled to one client who is having problems, all residents in the home are affected. The corrective measures identified here will address the needs of all clients at the facility. Measures or systemic changes facility put in place to ensure no recurrence Staff training on positioning, fence installation to increase safe area and slow behavioral elopement, and formalizing assistance from nearby homes will all be put in place to prevent recurrence. How corrective actions will be monitored to ensure no recurrence The Group Home Manager supervises staff,</p>		

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	<p>counseled client A as staff #7 assisted as well.</p> <p>At 5:50 PM, staff #7 cut a banana into bite sized (1/2 inch) pieces for client D. Staff #7 indicated client C was on a mechanical soft diet due to being a choking risk and client D's food was cut into bite sized pieces because she had a tendency to eat fast or take bites which were too big to be safe.</p> <p>Interview with staff #9 on 7/1/13 at 6:45 PM indicated clients were to be monitored at mealtimes but it took all 3 staff working to remove client A from the road. The interview indicated two staff were unable to keep the client out of the road despite their best efforts. The interview indicated client A was a one to one staffing ratio during waking hours because of her extreme behaviors.</p> <p>Client A's record was reviewed on 7/1/13 at 5:10 PM and 7/2/13 at 9:45 AM. The review indicated client A was five feet one inch tall and weighed 198.6 pounds as of 6/24/13. The review indicated a 7/1/13 (revision date) Behavior Support Plan/BSP. The BSP indicated the client's diagnoses included, but were not limited to, Chronic Depressive Disorder, Borderline Personality Disorder, Post-Traumatic Stress Disorder, Hydrocephalus, Shunt revision in head,</p>		<p>including ensuring that their training needs are met. Management staff complete home visit forms and will assist in monitoring the implementation of new corrections. The Director supervises staff and reviews home visit forms at regular staff meetings. The IDT meets regularly and reviews incidents. The agency's Incident Oversight Committee – comprised of the Director, an agency Vice President, and a Compliance Officer – reviews all incidents. When insufficient corrective action is put in place, the committee follows up with the agency's management staff.</p>				

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	<p>victim of sexual abuse and victim of Munchausen by proxy. The BSP indicated client A would elope from the premises and would threaten suicide, engage in self injury with intent at self harm (head banging, trying to jump from a height to damage/injure her head) and she had a history of PICA (eating inedible objects).</p> <p>Client C's record was reviewed on 7/1/13 at 6:28 PM and indicated the July 2013 doctor's order for a mechanical soft diet signed by the physician on 6/26/13. The review indicated a dining plan dated 5/27/13 which indicated the client was at risk for "choking (and) aspiration." The dining plan listed client C's diet as "mechanical soft ground meat, rice size pieces, chop all meat in chopper," moisten bread and cookies with milk, substitute pudding for ice cream, nectar thick liquids, "no food in front of her not mechanical soft." "Staff must remain at the table to maintain safety and provide prompts to take small bites, chew food thoroughly."</p> <p>A review of the facility's incident/investigative reports was conducted on 7/01/13 at 1:15 PM and indicated the following incidents with client A wherein she required more staff supervision to prevent incidents:</p>						

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	<p>1. 6/30/13 6:55 AM, client A took a double A battery from a television remote control and swallowed it. She was taken to a local emergency room and the battery was removed by a scope via her esophagus. Client A was one on one (one staff monitoring her) when the incident happened. Client A was admitted to the hospital and returned to the facility at 5:00 PM on 7/1/13.</p> <p>2. 6/12/13 4:30 PM, client A left the facility (eloped) via the back door and ran into the well traveled county road in front of the facility and laid down in the road with traffic coming from both directions (north/south). Staff providing one to one supervision plus a second staff were unable to keep her out of the road.</p> <p>3. 6/09/13 4:00 PM, client A went out the backdoor of the facility and used garden mulch to scratch her abdomen.</p> <p>4. 5/31/13 1:40 PM, client A became upset on the van returning from day program and was restrained by staff. Returned to facility but eloped and was brought back in to the facility by staff.</p> <p>5. 4/28/13 5:31 PM, client A eloped from the facility and obtained wooden garden mulch to cut self, staff took mulch away.</p>						

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	<p>6. 3/27/13 6:30 AM, client A eloped from the facility and staff coaxed client A back onto the property after 25 minutes.</p> <p>An interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 7/01/13 at 2:15 PM and on 7/02/13 at 5:30 PM. The QIDP indicated client A was a one to one (staff supervision level) because of her suicidal threats and behaviors of aggression, elopement and PICA. The interview indicated clients were to be supervised at all times and staff should not have left clients with choking risks unsupervised with food (client C). The interviews indicated at the time of the incident, three staff were not adequate for the supervision needs of the four clients (two staff plus a one to one which equaled 3). The interview indicated the staffing level had been raised to 2 to one ratio with client A (for a total of four staff) from 6:00 AM until 9:00 PM on 7/2/13 when it would be discussed and evaluated to see if it (two to one ratio for client A) was still required after 9:00 PM 7/2/13.</p> <p>This federal tag relates to complaint #IN00130955.</p> <p>9-3-3(a)</p>			

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