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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/05/2013 |
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| NAME OF PROVIDER OR SUPPLIER WARNER TRANSITIONAL SERVICES, LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 11075 N PENNSYLVANIA ST INDIANAPOLIS, IN 46280 |
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| W000000 | <p>This visit was for the investigation of complaints #IN00121785, #IN00122083 and #IN00122955.</p> <p>Complaint #IN00121785: Substantiated, Federal deficiencies related to the allegation(s) are cited at W102, W104, W122, W149 and W240.</p> <p>Complaint #IN00122083: Substantiated, Federal deficiencies related to the allegation(s) are cited at W289 and W331.</p> <p>Complaint #IN00122955: Substantiated, Federal deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W189, W154, W157, W227, W240, W267, W286, W289 and W331.</p> <p>Unrelated Deficiencies cited.</p> <p>Dates of Survey: 1/22, 1/23, 1/24, 1/25, 1/28 and 2/5/13</p> <p>Facility Number: 012836 AIMS Number: 201091250 Provider Number: 15G809</p> <p>Surveyors: Paula Chika, Medical Surveyor III-Team Leader</p> | W000000 | <p>Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that</p> <p>this Statement of Deficiency was correctly cited, and is</p> <p>also not to be construed as an admission of fault by</p> <p>the facility, the Executive Director or any employees,</p> <p>agents or other individuals who draft or may be</p> <p>discussed with this Response and Plan of Correction.</p> <p>In addition, preparation and submission of this Plan of</p> <p>Correction does not constitute an admission or</p> <p>agreement of any kind by the facility of the truth of any</p> <p>facts alleged or the correctness of any conclusions</p> <p>set forth in the allegations. Accordingly, the Facility has</p> <p>prepared and submitted this Plan of Correction prior to</p> <p>the resolution of any appeal which may be filed solely</p> <p>because of the requirements under State and federal</p> | |

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

TITLE

(X6) DATE

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

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| | <p>Claudia Ramirez, Public Health Nurse Surveyor III-RN</p> <p>Quality Review completed 2/11/13 by Ruth Shackelford, Medical Surveyor III.</p> | | <p>law that mandate submission of a Plan of Correction</p> <p>within specified days of the survey as a condition to</p> <p>participate in Title 18 and Title 19 programs. This Plan</p> <p>of Correction is submitted as the facility's credible</p> <p>allegation of compliance.</p> | |

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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, interview and record review, the facility failed to meet the Condition of Participation: Governing Body for 10 of 10 sampled clients (A, B, C, D, E, F, G, H, I and J) and for 18 additional clients (K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, A1 and B2). The facility's governing body failed to ensure the clients were not neglected, and/or in an environment to be potentially abused. The facility's governing body failed to conduct thorough investigations regarding allegations of neglect and/or abuse, to put in place corrective actions/measures involving incidents of physical aggression (client to client and/or client to staff), physical restraints, and to report an allegation of staff to client abuse immediately to the administrator. The governing body failed to develop a policy and procedure in regard to sexuality/sex between clients. The facility's governing body failed to ensure the facility did not violate clients' rights in regard to privacy.</p> <p>Findings include:</p> <p>1. The facility's governing body failed to ensure the facility met the Condition of</p> | W000102 | <p>The governing body will ensure facility staff report all allegations of abuse / neglect and injuries of unknown source immediately to the Administrator. Thorough investigations of these reports will be conducted and results of the investigations will be reported to the Administrator within 5 working days. This will be accomplished for all clients: 1. Reporting format will be changed to specifically note that the Administrator was notified immediately on report all allegations of abuse / neglect and injuries of unknown source, providing name of person notifying the Administrator, date, and time.</p> <p>· Reporting format to be completed by 3/7/13. · Responsible Party: Office Manager · Supervisors will be retrained on specifics requiring reports to be completed. · Responsible Party: Director of Operations (DOO) · Completed by 3/7/13. Additionally - · Transition Team Coordinators (TTC), Qualified Support Professionals, Lead Direct Support Professionals, and</p> | 03/23/2013 | | | |

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| | <p>Participation: Client Protections for 10 of 10 sampled clients (A, B, C, D, E, F, G, H, I and J) and for 18 additional clients (K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, A1 and B2). The governing body failed to ensure the facility implemented its policy and procedures to prevent neglect of clients due to behavioral incidents, conducted thorough investigations in regard to allegations of abuse, neglect, and/or injuries of unknown source, and to report all allegations to the administrator immediately. The governing body failed to develop needed policy and procedures regarding client to client sex. The governing body failed to put in place corrective measures/actions to decrease the amount of physical aggression and clients' behaviors to ensure clients and staff worked in a safe environment to prevent potential abuse of clients. Please see W122.</p> <p>2. The facility's governing body failed to ensure the facility implemented its policy and procedures to prevent neglect of clients in regard to an elopement incident, an incident of self harm and in regard to a sexual incident between two clients. The facility's governing body failed to ensure the facility developed a policy and procedure which outlined how the facility would deal with clients' relationships</p> | | <p>Health Services Staff will monitor the appropriate forms to ensure the proper reporting of reportable incidents to the Administrator. · Timely (within 5 working days) investigative reports will be completed with corrective actions/measures put in place and received/reviewed by Administrator – tracked by Quality Assurance and Investigators. · On-going.</p> <p>2. Facility staff have received training on attached # 1 new “Client Sexual Relationships Policy”, specifically in regard to client monitoring and addressing interpersonal sexuality and overt sexual activity per facility policy. · Responsible Parties: Treatment Team Coordinators (TTC) to assure all staff follow the “Client Sexual Relations Policy” and are following policy · Completed by 2/28/13.</p> <p>RESUBMISSION #2 of Item 3 below 3 a) The facility's governing body will ensure the facility does not violate clients' rights in regard to privacy. · A separate audio permission has been added to client/guardian/health care representative consent (attachment revised consent form – audio/video) for surveillance of the commons areas, which had only video</p> | | | | |

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| | <p>and/or sexual activity between clients. The facility's governing body failed to ensure the facility implemented its policy and procedures to prevent neglect of clients and/or potential abuse of clients as the facility did not have a working system to monitor for patterns and trends in regard to client to client incidents, client to staff incidents which resulted in injury/significant injuries, and/or the increased amount of physical restraints which were utilized by facility staff. The facility's governing body failed to ensure the facility provided a safe environment for clients and staff to prevent potential abuse of clients A, B, C, D, F, G, H, I, R and U.</p> <p>The facility's governing body failed to ensure clients had the right to privacy and/or due process in regard to the facility's usage of audio surveillance/taping clients when in all common areas of the facility for clients A, B, C, D, E, F, G, H, I, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, A1 and B2.</p> <p>The facility's governing body failed to ensure the facility provided evidence an allegation of staff to client abuse was immediately reported to the administrator for client E. The facility's governing body failed to ensure the facility conducted thorough investigations in regard to</p> | | <p>previously noted on the consent form. - Policy revised 3/4/13 to reflect audio recording – attached. - Steps will be taken to ensure the use of audio and video systems does not invade the privacy of clients in areas where there is a reasonable expectation of privacy.</p> <ul style="list-style-type: none"> o To ensure conversations in non-common areas are not being recorded there are no recording devices of any kind in the private living areas (bedrooms/restrooms). o Assessment of audio sensitivity from cameras in hallways by client bedrooms will be completed to assure that private conversations are not recorded from hallway cameras when client bedroom doors are shut; o Audio in commons areas where restrooms are present (client canteen and art room) will have audio sensitivity reduced so as not to pick up any audio from restrooms; o Audio from any cameras in conference rooms, client phone calling areas will be eliminated; o Responsible Party – WTS Safety & Security/Facility Maintenance and camera security contractor; o Date to be completed by: 3/23/13 with audio sensitivity to be reduced as necessary. Follow-up checks to be performed | | | | |

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| | <p>allegations of abuse, neglect and/or injuries of unknown source reviewed, and/or failed to provide evidence all allegations of abuse/neglect and/or injuries of unknown source were investigated for clients A, B, C, D, G, H, E, F, I, R, U, M and Z. The facility's governing body failed to initiate and document effective corrective action to prevent further incidents of client to client aggressive behavior, client to staff aggressive behavior and provide an environment to address and decrease the number of aggressive incidents involving clients A, B, D, E, G, H, M, P, R, U and Z. Please see W104.</p> <p>This federal tag relates to complaints #IN00121785 and #IN00122955.</p> | | <p>semi-annually as part of quality assurance process. - Any audio/video recording in the proximity of these areas will only be reviewed to insure the health, safety and well-being of clients and staff, including addressing required investigations for any reports of abuse/neglect and client to client aggression. · Human Rights Committee has approved the audio addition to the video surveillance of the overall surveillance of the common areas of the facility; o Completed on: 1/31/13 o Responsible Party who presented to HRC: Behavioral Services Coordinator; · Clients/ legal guardians/health care representatives will have the addition to the surveillance form presented to them for approval; · Responsible Party: Admissions Coordinator · Date to be addressed with clients – 3/7/13; with consents to legal guardians/health care representatives in active process by: 3/7/13 3 b) Clients/legal guardians/health care representatives will be assured that privacy is secure in the personal areas of bedrooms, rest rooms, bathing areas, conference rooms, and telephone and in therapist/QSP offices. o Responsible party: Admissions Coordinator to</p> | |

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| | | | <p>initially make all client/ legal guardian / health care representative contacts regarding facilities commitment to privacy. The QSPs, TTCs, Program Director and Administrator also will be readily available to immediately address any issue regarding client privacy, especially related to the video/audio surveillance. o Date to be addressed with clients/legal guardians/health care representatives – 3/7/13 in active process and on-going via WTS administrative and clinical staff as issues/questions arise from clients/legal guardians/health care representatives.</p> | |

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| W000104 | <p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review for 10 of 10 sampled clients (A, B, C, D, E, F, G, H, I and J) and for 18 additional clients (K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, A1 and B2), the facility's governing body failed to exercise general policy and operating direction over the facility to ensure the clients were not neglected and/or in an environment to be potentially abused. The facility's governing body failed to exercise general policy and operating direction over the facility to conduct thorough investigations regarding allegations of neglect and/or abuse, to put in place corrective actions/measures involving incidents of physical aggression, physical restraints and/or client to staff aggression, to report an allegation of staff to client abuse immediately to the administrator and to develop a policy and procedure in regard to sexuality/sex between clients. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility did not violate clients' rights in regard to privacy.</p> | W000104 | <p>1. Reporting format has been changed to specifically note that the Administrator was notified immediately of all reportable incidents/events, providing name of person notifying Administrator, date, and time. · Responsible Party: Office Manager/Quality Assurance Director to implement; · Reporting format to be completed/operational by 3/7/13 · Supervisors retrained on specifics requiring reports to be completed. · Responsible Party: Director of Operations · To be Completed by 3/7/13. · Quality Assurance Director will monitor thorough reporting and accompanying investigations for a pattern of allegations of neglect and/or abuse. · Per investigation "corrective action" outcomes the TTC's will put into place and assure all staff working with client(s) are trained on the corrective actions/measures involving incidents of physical aggression, physical restraints and/or client to staff; · To be fully implemented by: 3/7/13</p> <p>2. Facility staff have received training on attached #1 new</p> | 03/23/2013 | | | |

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| | <p>Findings include:</p> <p>1. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of clients in regard to an elopement incident, an incident of self harm and in regard to a sexual incident between two clients. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility developed a policy and procedure which outlined how the facility would deal with clients' relationships and/or sexual activity between clients. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of clients and/or potential abuse of clients as the facility did not have a working system to monitor for patterns and trends in regard to client to client incidents, client to staff incidents which resulted in injury/significant injuries, and/or the increased amount of physical restraints which were utilized by facility staff. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility provided a safe environment for clients and staff to prevent potential abuse</p> | | <p>“Client Sexual Relationships Policy”, specifically in regard to client monitoring and addressing interpersonal sexuality and overt sexual activity per facility policy. · Responsible Parties: Treatment Team Coordinators (TTC) to assure all staff follow the “Client Sexual Relations Policy” and are following policy · Completed by 2/28/13. Resubmission #2 of item 3</p> <p>3 a) The facility's governing body will ensure the facility does not violate clients' rights in regard to privacy. · A separate audio permission has been added to client/guardian/health care representative consent (attachment revised consent form – audio/video) for surveillance of the commons areas, which had only video previously noted on the consent form. - Policy revised 3/4/13 to reflect audio recording – attached. - Steps will be taken to ensure the use of audio and video systems does not invade the privacy of clients in areas where there is a reasonable expectation of privacy. o To ensure conversations in non-common areas are not being recorded there are no recording devices of any kind in the private living areas (bedrooms/restrooms).</p> | | | | |

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| | <p>of clients A, B, C, D, F, G, H, I, R and U. Please see W149.</p> <p>2. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure clients had the right to privacy and/or due process in regard to the facility's usage of audio surveillance/taping clients when in all common areas of the facility for clients A, B, C, D, E, F, G, H, I, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, A1 and B2. Please see W125.</p> <p>3. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility provided evidence an allegation of staff to client abuse was immediately reported to the administrator for client E. Please see W153.</p> <p>4. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted thorough investigations in regard to allegations of abuse, neglect and/or injuries of unknown source reviewed, and/or failed to provide evidence all allegations of abuse/neglect and/or injuries of unknown source were investigated for clients A, B, C, D, G, H, E, F, I, R, U, M and Z. Please see W154.</p> | | <p>o Assessment of audio sensitivity from cameras in hallways by client bedrooms will be completed to assure that private conversations are not recorded from hallway cameras when client bedroom doors are shut; o Audio in commons areas where restrooms are present (client canteen and art room) will have audio sensitivity reduced so as not to pick up any audio from restrooms; o Audio from any cameras in conference rooms, client phone calling areas will be eliminated; o Responsible Party – WTS Safety & Security/Facility Maintenance and camera security contractor; o Date to be completed by: 3/23/13 with audio sensitivity to be reduced as necessary. Follow-up checks to be performed semi-annually as part of quality assurance process. - Any audio/video recording in the proximity of these areas will only be reviewed to insure the health, safety and well-being of clients and staff, including addressing required investigations for any reports of abuse/neglect and client to client aggression. · Human Rights Committee has approved the audio addition to the video surveillance of the overall surveillance to the</p> | |

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| | <p>5. The facility's governing body failed to exercise general policy and operating direction over the facility to initiate and document effective corrective action to prevent further incidents of client to client aggressive behavior, client to staff aggressive behavior and provide an environment to address and decrease the number of aggressive incidents involving clients A, B, D, E, G, H, M, P, R, U and Z. Please see W157.</p> <p>This federal tag relates to complaints #IN00121785 and #IN00122955.</p> | | <p>common areas of the facility; o Completed on: 1/31/13 o Responsible Party who presented to HRC: Behavioral Services Coordinator; · Clients/legal guardians/health care representatives will have the addition to the surveillance form presented to them for approval; · Responsible Party: Admissions Coordinator · Date to be addressed with clients – 3/7/13; with consents to legal guardians/health care representatives in active process by: 3/7/13 3 b) Clients/legal guardians/health care representatives will be assured that privacy is secure in the personal areas of bedrooms, rest rooms, bathing areas, conference rooms, and telephone and in therapist/QSP offices. o Responsible party: Admissions Coordinator to initially make all client/ legal guardian / health care representative contacts regarding facilities commitment to privacy. The QSPs, TTCs, Program Director and Administrator also will be readily available to immediately address any issue regarding client privacy, especially related to the video/audio surveillance. o Date to be addressed with clients/legal guardians/health care representatives – 3/7/13 in</p> | | |

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| | | | active process and on-going via WTS administrative and clinical staff as issues/questions arise from clients/legal guardians/health care representatives. | | |

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| W000122 | <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review the facility to meet the Condition of Participation: Client Protections for 10 of 10 sampled clients (A, B, C, D, E, F, G, H, I and J) and for 18 additional clients (K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, A1 and B2). The facility neglected to implement its policy and procedures to prevent neglect of clients due to behavioral incidents, conducting thorough investigations in regard to allegations of abuse, neglect, and/or injuries of unknown source, and to report all allegations to the administrator immediately. The facility failed to develop needed policy and procedures regarding client to client sex, and to put in place corrective measures/actions to decrease the amount of physical aggression/clients' behaviors to ensure clients and staff worked in a safe environment to prevent potential abuse of clients.</p> <p>Findings include:</p> <p>1. The facility failed to implement its policy and procedures to prevent neglect of clients in regard to an elopement incident, an incident of self harm and in regard to a sexual incident between two</p> | W000122 | <p>1. Facility will: Ø Ensure that all clients on offsite outings related to WTS have a minimum of two staff in supervision – with even a minimum of one client attending outing. · Staff transporting clients have been re-trained on this staff supervision outing requirement' · Responsible Parties: Treatment Team Coordinators (TTCs) · Date to be Fully Implemented: 1/18/13 Ø Facility staff have received training on (attached #1) new "Client Sexual Relationships Policy", specifically in regard to client monitoring and addressing interpersonal sexuality and overt sexual activity per facility policy. · Responsible Parties: Treatment Team Coordinators (TTC) to assure all staff follow the "Client Sexual Relations Policy" and are following policy · Completed by 2/28/13. Ø The facility will implement a quality assurance system to monitor for patterns and trends in regard to client to client incidents, client to staff incidents which resulted in injury/significant injuries, and/or the increased amount of</p> | 03/07/2013 |
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| | <p>clients. The facility also failed to develop a policy and procedures which outlined how the facility would deal with clients' relationships and/or sexual activity between clients. The facility failed to implement its policy and procedures to prevent neglect of clients and/or potential abuse of clients as the facility did not have a working system to monitor for patterns and trends in regard to client to client incidents, client to staff incidents which resulted in injury/significant injuries, and/or the increased amount of physical restraints which were utilized by facility staff. The facility failed to ensure a safe environment existed for clients and staff to prevent potential abuse of clients A, B, C, D, F, G, H, I, R and U. Please see W149.</p> <p>2. The facility failed to ensure clients had the right to privacy and/or due process in regard to the facility's usage of audio surveillance/taping clients when in all common areas of the facility for clients A, B, C, D, E, F, G, H, I, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, A1 and B2. Please see W125.</p> <p>3. The facility failed to provide evidence an allegation of staff to client abuse was immediately reported to the administrator for client E. Please see W153.</p> | | <p>physical restraints which were utilized by facility staff.</p> <p>Quality Assurance Director will develop and implement systems to identify patterns and trends.</p> <p>Date to be operational: 3/7/13</p> <p>Ø See W 149</p> <p>2. The facility's governing body will ensure the facility does not violate clients' rights in regard to privacy.</p> <p>Audio permission has been added to client/guardian/health care representative consent (attached # 2) for surveillance of the commons areas, which had only video previously noted on the consent form.</p> <p>Responsible Party: Admissions Coordinator</p> <p>Date to be completed with consent: 3/7/13</p> <p>3. All allegations of abuse, neglect and/or injuries of unknown source will be immediately reported to the Administrator, (attachment # 4)</p> <p>Reporting format has been changed to specifically note that the Administrator was notified immediately of a pattern of injuries of unknown source of clients, who were being restrained, were not injured as a result of the restraint and/or abuse, providing name of person notifying Administrator, date, and time.</p> <p>Responsible Party: Office Manager</p> <p>To be fully operational be: 2/5/13</p> | | |

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| | <p>4. The facility failed to conduct thorough investigations in regard to allegations of abuse, neglect and/or injuries of unknown source reviewed, and/or failed to provide evidence all allegations of abuse/neglect and/or injuries of unknown source were investigated for clients A, B, C, D, G, H, E, F, I, R, U, M and Z. Please see W154.</p> <p>5. The facility failed to initiate and document effective corrective action to prevent further incidents of client to client aggressive behavior, client to staff aggressive behavior and provide an environment to address and decrease the number of aggressive incidents involving clients A, B, D, E, G, H, M, P, R, U and Z. Please see W157.</p> <p>This federal tag relates to complaints #IN00121785 and #IN00122955.</p> | | <p>Supervisors have been retrained on specifics requiring reports to be completed for proper notification.</p> <p>Responsible Party: Director of Operations (DOO)</p> <p>Completed by: 2/5/13.</p> <p>4. The facility will conduct thorough investigations/provide a reproducible system of its investigations and results will be reported to Administrator within 5 business days,</p> <p>Quality Assurance Director will assure designated investigative staff receive proper training in completing investigations, including investigations of allegations of abuse, neglect and injuries of unknown source and will provide evidence of investigations through a maintained reproducible system of investigations.</p> <p>ISDOH survey supervisor conducted a 2 – hour training on investigations on 2/14/13 attended by professional staff, including the Investigators and Quality Assurance Director;</p> <p>Person Responsible: Quality Assurance Director</p> <p>Investigative process to be fully operational by: 3/7/13</p> <p>5. Facility staff have received retraining on the Handle With Care® Primary Restraint Technique (PRT), specifically with respect to the proper</p> | | | | |

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| | | | <p>timing of use of physical restraint focusing on verbal deescalation of behaviors to resolve need for use of a physical restraint · National trainer (New York) from Handle With Care® will complete annual “train the trainer” on 2/4 – 2/7/13 with focus being given to de-escalation techniques, proper physical restraint techniques and prevention of injury / use of modified techniques. · Responsible Party: Human Resources Coordinator · Additionally modified PRTs or alternate methods of addressing client behavior will be designated for those individuals who may be potentially harmed in the application of a PRT due to physical condition. · Responsible Parties: Treatment Team Coordinators by 2/7/13. (Additionally) · Behavioral Services Coordinator is reevaluating alternative methods to avert client aggression by individually assessing client BSPs and implementing changes as alternative resources to be utilized for clients to avert aggressive/ destructive behaviors. · Clients to be reassessed with addendums to BSPs with approval per Human Rights Committee and legal</p> | |

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| | | | guardian/HCR or other court appointed advocate as required by: 3/7/13 | | |

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| W000125 | <p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview and record review for 10 of 10 sampled clients (A, B, C, D, E, F, G, H, I and J) for 18 additional clients (K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, A1 and B2), the facility failed to ensure clients had the right to privacy and/or due process in regard to the facility's usage of audio surveillance/taping clients when in all common areas of the facility.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, BIRS (Behavior Incident Reports) and/or investigations were reviewed on 1/23/13 at 10:29 AM. The facility's 1/13/13 reportable incident report indicated "On 1-13-2013, it was reported to staff by [client A], individual, that she had sex with her boyfriend, [client I], while in the bathroom of the Canteen room...Investigation results were unable to substantiate if sexual intercourse has actually taken place due to a lack of video access to the bathroom. Staff [staff #11], who was monitoring the individuals</p> | W000125 | <p>The facility's governing body will ensure the facility does not violate clients' rights in regard to privacy.</p> <p>Audio permission has been added to client/guardian/health care representative consent (attached #2) for surveillance of the commons areas, which had only video previously noted on the consent form.</p> <p>Human Rights Committee has approved the audio addition to the video surveillance of the overall surveillance of the common areas of the facility</p> <p>o Completed on: 1/31/13</p> | 03/07/2013 | | | |

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| | <p>during their visitation, was suspended and consequently terminated on 1-18 due to poor judgement of allowing these two individuals to spend time together in the restroom, although both were consenting adults and both requested to go into the restroom together."</p> <p>The facility's 1/14 and 1/15/13 Internal Investigation Report indicated "On 1-13-13, [client A and client I] (currently a couple) were in the Canteen room for an evening visit. Staff, [staff #11], was supervising the visit. Upon returning from the visit, [client A] stated to staff [staff #12] that she had sex that evening with her boyfriend, [client I] while in the Canteen room bathroom... I asked her where the staff was at, she told me that he (staff #11) was sitting in the chair and that he them permission to go into the bathroom (sic)...."</p> <p>The facility's recorded/audio tape was reviewed on 1/23/13 at 3:35 PM. The video/audio tape was of clients A and I and staff #11 in the Canteen room of the facility at 9:46 PM on 1/13/13. The video/audio tape indicated music was playing in the canteen which prevented clients A and I's conversation from being heard. The video tape did indicate the clients were sitting in one area of the canteen and staff #11 was on the other</p> | | <ul style="list-style-type: none"> o Responsible Party who presented to HRC: Behavioral Services Coordinator; · Clients, legal guardians and / or health care representatives will have the addition to the surveillance form presented to them for approval; · Responsible Party: Admissions Coordinator · Date to be completed with consents by: 3/7/13 | | | | |

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| | <p>side of the room looking at a magazine. Clients A and I could be seen talking/whispering to each other and looking over to staff. At 9:52 PM, the video indicated the clients cut the music off. The video indicated client A asked staff if they could spend the last 5 minutes of their visitation in the bathroom of the Canteen. The video/audio tape showed staff #11 asked clients A and I if this was in their program. The video/audio tape indicated both clients stated "Yes." Staff #11 saluted clients A and I and both clients walked into the Canteen bathroom and closed the bathroom door. Staff #11 sat in the Canteen room whistling, stood whistling and walked out of sight of the camera at 9:57 AM at the door/entrance of the Canteen Room. Staff #11 could still be heard whistling even though the staff could not be seen. Staff #11 then stated to the clients in the bathroom, "It is a little after 10." Client A responded "Ok." Client A could be heard moaning/making sounds, in the Canteen bathroom, with the door closed. At 10:04 PM, staff #11 stated "You got to wrap it up. Wrap it up." Client A again could be heard moaning and making sounds in the Canteen bathroom. At 10:07 PM, staff #1 stated "We got to roll. We got to roll." At 10:09 PM, Clients A and I came out of the bathroom dressed with client A trying to straighten out her hair with her hand.</p> | | | | |

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| | <p>Clients A and I retrieved their items from the table and began to walk out of the Canteen room.</p> <p>During the 1/22/13 observation period between 3:55 PM and 6:00 PM, at the facility, cameras were observed in the day room, hallways of the unit, hallways of the facility and in the dining room where clients A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, A1 and B2 lived/resided.</p> <p>Client A's record was reviewed on 1/23/13 at 5:00 PM. Client A's 9/10/12 Individual Support Plan (ISP) indicated the client was admitted to the facility on 11/13/12. Client A's December 2012 ISP indicated client A was her own guardian. Client A's record and/or ISP did not indicate client A gave written consent, and/or was made aware the facility audio taped the client's conversations in the facility. Client A's record did not include any documentation and/or consents in regard to the facility's video/audio surveillance. Client A's 12/12 ISP also did not indicate the facility's Human Rights Committee reviewed and/or approved the restrictive practice/rights violation.</p> | | | | |

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| | <p>Client B's record was reviewed on 1/24/13 at 4:13 PM. Client B's 12/10/12 ISP indicated the client was admitted to the facility on 11/9/12. Client B's 12/10/12 ISP indicated client B was his own guardian. Client B's record and/or ISP did not indicate client B gave written consent, and/or was made aware the facility audio taped the client's conversations in the facility. Client B's record did not include any documentation and/or consents in regard to the facility's video/audio surveillance. Client B's 12/10/12 ISP also did not indicate the facility's Human Rights Committee reviewed and/or approved the restrictive practice/rights violation.</p> <p>Client C's record was reviewed on 1/23/13 at 11:26 AM. Client C's 9/4/12 ISP indicated the client was admitted to the facility on 9/21/12. Client C's December 2012 ISP indicated client C was her own guardian. Client C's record and/or ISP did not indicate client C gave written consent, and/or was made aware the facility audio taped the client's conversations in the facility. Client C's</p> | | | |
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| | <p>record did not include any documentation and/or consents in regard to the facility's video/audio surveillance. Client C's 9/4/12 ISP also did not indicate the facility's Human Rights Committee reviewed and/or approved the restrictive practice/rights violation.</p> <p>Client D's record was reviewed on 1/24/13 at 3:24 PM. Client D's 9/10/12 ISP indicated the client was admitted to the facility on 8/20/12. Client D's 9/10/12 ISP indicated client D's step father was his legal guardian. Client D's record and/or ISP did not indicate client D's legal guardian gave written consent, and/or was made aware the facility audio taped the client's conversations in the facility. Client D's record did not include any documentation and/or consents in regard to the facility's video/audio surveillance. Client D's 9/10/12 ISP also did not indicate the facility's Human Rights Committee reviewed and/or approved the restrictive practice/rights violation.</p> <p>Client E's record was reviewed on 1/23/13 at 1:24 PM. Client E's 10/23/12 Transition Support Plan (TSP) indicated</p> | | | |

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| | <p>the client was admitted to the facility on 10/2/12. Client E's 10/23/12 program plan indicated client E was her own guardian. Client E's record and/or TSP did not indicate client E gave written consent, and/or was made aware the facility audio taped the client's conversations in the facility. Client E's record did not include any documentation and/or consents in regard to the facility's video/audio surveillance. Client E's 10/23/12 TSP also did not indicate the facility's Human Rights Committee reviewed and/or approved the restrictive practice/rights violation.</p> <p>Client F's record was reviewed on 1/25/13 at 1:45 PM. Client F's Undated TSP indicated the client was admitted to the facility on 11/26/12. Client F's undated TSP indicated client F's parents were her legal guardians. Client F's record and/or ISP did not indicate client F's legal guardians gave written consent, and/or were made aware the facility audio taped the client's conversations in the facility. Client F's record did not include any documentation and/or consents in regard to the facility's video/audio surveillance.</p> | | | | |

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| | <p>Client F's undated TSP also did not indicate the facility's Human Rights Committee reviewed and/or approved the restrictive practice/rights violation.</p> <p>Client G's record was reviewed on 1/24/13 at 2:31 PM. Client G's 9/10/12 ISP indicated the client was admitted to the facility on 10/2/12. Client G's 10/25/12 ISP indicated client G was his own guardian. Client G's record and/or ISP did not indicate client G gave written consent, and/or was made aware the facility audio taped the client's conversations in the facility. Client G's record did not include any documentation and/or consents in regard to the facility's video/audio surveillance. Client G's 10/25/12 ISP also did not indicate the facility's Human Rights Committee reviewed and/or approved the restrictive practice/rights violation.</p> <p>Client H's record was reviewed on 1/24/13 at 1:06 PM. Client H's 12/10/12 ISP indicated the client was admitted to the facility on 11/9/12. Client H's 12/10/12 ISP indicated client H had a legal guardian. Client H's record and/or</p> | | | | | | |

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| | <p>ISP did not indicate client H's legal guardian gave written consent, and/or was made aware the facility audio taped the client's conversations in the facility. Client H's record did not include any documentation and/or consents in regard to the facility's video/audio surveillance. Client H's 12/10/12 ISP also did not indicate the facility's Human Rights Committee reviewed and/or approved the restrictive practice/rights violation.</p> <p>Client I's record was reviewed on 01/24/13 at 11:06 AM. Client I's 9/10/12 Individual Support Plan (ISP) indicated the client was admitted to the facility on 8/20/12. Client I's 8/20/12 ISP indicated client I was his own guardian. Client I's record and/or ISP did not indicate client I gave written consent, and/or was made aware the facility audio taped the client's conversations in the facility. Client I's record did not include any documentation and/or consents in regard to the facility's video/audio surveillance. Client I's 9/10/12 ISP also did not indicate the facility's Human Rights Committee reviewed and/or approved the restrictive practice/rights violation.</p> | | | |

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| | <p>Client J's record was reviewed on 1/25/13 at 10:20 AM. Client J's 12/7/12 TSP indicated the client was admitted to the facility on 11/7/12. Client J's 12/7/12 TSP indicated client J was her own guardian. Client J's record and/or TSP did not indicate client J gave written consent, and/or was made aware the facility audio taped the client's conversations in the facility. Client J's record did not include any documentation and/or consents in regard to the facility's video/audio surveillance. Client J's 12/7/12 TSP also did not indicate the facility's Human Rights Committee reviewed and/or approved the restrictive practice/rights violation.</p> <p>A blank copy of the facility's undated Notification of Use of Live & (and) Recorded Video was reviewed on 1/23/13 at 4:07 PM. The facility's blank consent form indicated "Warner Transitional Services (WTS) utilizes live and recorded video to ensure the protection of each client's rights and to assist with maintaining the safety and well being of our clients and staff. Cameras are placed throughout WTS only in community/public areas and are not</p> | | | | | | |

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| | <p>placed in or positioned to view inside bedrooms or restrooms. Viewing of video is supervised by our Safety/Security Professional (SSP) and/or designee and is limited to the Executive Director/Administrator, the SSP, and other supervisory staff who are approved by the Director and/or the SSP. By signing this form, I acknowledge that I understand that my actions and behavior at WTS are subject to live and recorded video, as well as monitoring by designated members of WTS' Administrative and Treatment Teams." The above mentioned consent form did not indicate the facility informed and/or obtained written informed consent for the use of Audio surveillance.</p> <p>Interview with TTC (Treatment Team Coordinator) #1 and #2 on 1/23/13 at 3:00 PM indicated sounds could be heard coming from the bathroom during the 1/13/13 incident up on review of the audio tape.</p> <p>Interview with Safety and Security Professional (SSP) #1 and administrative staff #2 on 1/23/13 at 3:45 PM indicated there was a microphone located on the camera in the Canteen room. SSP #1 indicated the cameras throughout the entire facility all had microphones on them. SSP #1 stated "The audio was only</p> | | | |

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| | <p>on when needed." The SSP indicated when the video recorded footage audio would also be recorded. The SSP indicated all security personnel had access to the cameras/audio when monitoring the building/facility and when conducting investigations. SSP #1 indicated the facility had a total of 180 cameras located throughout the facility.</p> <p>Interview with Treatment Team Coordinator (TTC) #1 on 1/23/13 at 4:55 PM indicated the clients, who resided at the facility, were aware they were being audio recorded. TTC #1 indicated the clients and/or the clients' guardians gave written consent and the forms were located in the clients' records.</p> <p>Interview with TTC #1 and the Qualified Support Professional (QSP) #2 on 1/28/13 at 12:10 PM indicated clients A, B, C, D, F, G, H, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, A1 and B2 were aware the facility utilized cameras with audio surveillance. When asked where the consent forms were located in each client's record, TTC #1 stated the consent forms were actually in each client's over flow chart, and not in the "working record."</p> <p>Interview with administrative staff #1, #3, #4, #5 and TTC #1 on 1/28/13 at 3:59 PM</p> | | | | | | |

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| | <p>indicated the facility utilized video and audio surveillance. Administrative staff #3, #4 and #5 indicated clients were aware they were being audio and video taped. Administrative staff #3, #4 and #5 indicated the use of the audio and video tapes helped with the facility's investigations and when "He said, She said" occurred. Administrative staff #3 stated "It allows us to hear what was said." Administrative staff #1 indicated the cameras were located in the common areas of the facility. Administrative staff #1 indicated there were no cameras in the clients' bedrooms, bathrooms, therapist offices, QSPs office, Behavior Specialist office, staff lounges and the conference room. Administrative staff #1 indicated the audio could not pick up conversations. Administrative staff #3 and #5 shook their heads, yes, when it was mentioned clients A and I could be heard making sounds/having sex in the bathroom of the Canteen room. Administrative staff #1 indicated the cameras with audio capabilities had been installed in the building prior to the opening of the facility in August 2012. Administrative staff #1 indicated the facility's Human Rights Committee had not reviewed the facility's restrictive practice/usage of the video/audio surveillance to ensure the protection of the clients' rights.</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, interview and record review for 4 of 10 sampled clients (A, C, F, and I), the facility neglected to implement its policy and procedures to prevent neglect of clients in regard to an elopement incident, an incident of self harm and in regard to a sexual incident between two clients. The facility also neglected to develop policy and procedures which outlined how the facility would deal with clients' relationships and/or sexual activity between clients.</p> <p>Based on interview and record review for 4 of 10 sampled clients (B, D, G, H and I) and for 2 additional clients (R and U), the facility neglected to implement its policy and procedures to prevent neglect of clients and/or potential abuse of clients as the facility did not have a working system to monitor for patterns and trends in regard to client to client incidents, client to staff incidents which resulted in injury and/or significant injuries, and/or the increased amount of physical restraints which were utilized by facility staff. The facility neglected to ensure a safe environment existed for clients and staff to prevent potential abuse of clients.</p> | W000149 | <p>The facility will exercise general policy, procedure and operating direction over the facility to ensure policy, procedures and guidelines are followed as directed to prevent client neglect. a) Client outings – all staff have been directed to: i. No single staff/minimum of two staff on any client outing – even with one client; ii. Any off-site outing as assessed and outlined in individual ISPs will be followed without exception, iii. Staff transporting clients have been retrained on this supervised outing requirement; iv. Responsible Party: Treatment Team Coordinators v. Date Completed: 1-18-13 b) The policy for Suicidal Client Management, which addresses client precautions, was revised 1-24-13 specifically addresses 1 to 1 continuous “line of sight” in monitoring of clients who may self-harm or otherwise place themselves in an unsafe situation. (attached #3) i. Responsible Party: Director of Operations & Treatment Team Coordinators to train and monitor client supervision as indicated; ii.</p> | 03/07/2013 | |

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| | <p>Findings include:</p> <p>1. The facility's reportable incidents, Behavior Incident Reports (BIRS) and/or investigations were reviewed on 1/23/13 at 10:29 AM. The reportable incident reports indicated the following:</p> <p>-11/9/12 "[Client C] was in her room and sent another client with a note for staff. [Client C] had written that she would be dead by morning. When staff went to her room to speak with [client C] they found a bra tied around her neck. She allowed staff to help her remove the bra. [Client C] told staff that her peer's constant behaviors were just too much, that this peer took all of staff's attention. [Client C] said that she had swallowed pieces of her broken CD and pushed a pencil up into her private area and was referring to this rather than a needle. [Client C] was seen by the nurse and evaluated. The Doctor gave orders for her to be seen in the emergency room. She was also placed on Level 1 Suicide Precautions (arm length reach of staff at all times). The report from the ER (emergency room) found no evidence that she had swallowed any non-edible objects and could only state there may be a particle under the skin of her arm but they could not remove it but to follow-up (with) orthopedist or</p> | | <p>Date to be Completed: 3-7-13 all staff trained / monitoring for compliance – ongoing c) Facility staff have received training on (attached #1) new “Client Sexual Relationships Policy” i. Responsible Parties: Treatment Team Coordinators (TTC) to train & assure all staff follow the “Client Sexual Relations Policy” and are following policy ii. To be Completed by: 3/7/13 all staff trained on policy and related monitoring of policy is properly implemented - ongoing.</p> | |
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| | <p>surgeon if they felt it is necessary...." The 11/9/12 reportable incident report indicated when client C was placed on Level 1 Suicide Precautions, all of client C's belongings except clothing would be removed from the client's bedroom to prevent self harm. The reportable incident report indicated client C would have to sleep in an observation room, at night, to ensure she did not have access to any objects to harm herself with.</p> <p>A 11/22/12 follow-up report indicated client C "...had scratches on both wrists as well as a cut on her left wrist. It was not confirmed what the exact item was that [client C] had inserted into her vagina; however evidence suggests that she did in fact have a foreign object placed in there at some point. She used the restroom immediately prior to leaving the facility to go to the hospital and staff reported seeing blood on the toilet paper after she wiped. The nurse assessed [client C] for injury and reported she did have abrasions in her genital area; however the injuries were not significant enough to warrant medical attention beyond first aid care.... [Client C] had an x-ray performed at the Emergency Room...The hospital reported that [client C] had a foreign object lodged beneath her skin in the left ulna/radius. The image shows that the particle is approximately 1/2 inch in length. The</p> | | | | |

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| | <p>recommendations of the hospital were to see if the particle would surface on its own through the healing process but to seek surgical consult if it does not appear. [Name of doctor], [client C's] primary care physician has been notified of these recommendations. He is scheduled to be at WTS (Warner Transitional Services) on Saturday November 17, 2012 and will be seeing [client C] for a follow-up as well as a referral for consult. 'Update' [Name of doctor] stated that he does not feel a need for [client C] to seek medical/surgical consult because her wound has completely healed over without any signs of irritation or infection. Unless it presents a problem at a later date, he does not recommend WTS pursue any further treatment for the wound/removal of the object..." The 11/22/12 follow-up report indicated client C was removed from Level 1 Suicide Precautions to Level 2 Suicide Precautions (within staff sight) until November 21, 2012 and placed on "self-harm observation (remain in staff's sight at all times)." The follow-up report indicated "Self-Harm Observation: Per order from psychiatrist, client is to remain in staff's sight at all times, can have no personal items in her room, cannot wear hooded shirts or heavy jackets, or long sleeve shirts. Client is also restricted from all sharps and pens. Client cannot</p> | | | |

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| | <p>have plastic silverware and must keep arms out of shirt at all times. Client is able to sleep in own room again. She can keep objects and belongings in her room that she does not self harm with...." The follow-up report further indicated client C admitted she did not harm herself due to another client's behavior but due to "...feeling sad about her past issues with children...." The follow-up report and/or 11/9/12 reportable incident report neglected to indicate any additional investigation in regard to neglect involving staff supervision and/or monitoring.</p> <p>-12/18/12 "At approximately 10:14pm on 12/18/2012, [client C] was in her bedroom. Her roommate walked into the room and noticed that [client C's] hands and head were underneath the covers. She (roommate) asked her (client C) to take her hands out so that she could see them and [client C] refused. Her roommate then went to alert staff that she thought [client C] was 'up to something.' Staff immediately went into [client C's] room. When they entered, head was peeking out of the covers (sic). Staff asked her to remove her hands from under the covers. She complied. She showed her right arm which had a cut/scrape on the right wrist. She stated that she had pieces of broken plastic from her DVD</p> | | | | |

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| | <p>player that she had inserted in there. She also said that she had swallowed some pieces of the same material. When staff had her take off the covers completely, they noticed she had abrasions to her neck where she had tied a cord to the DVD player around herself. Staff asked [client C] why she was trying to hurt herself. [Client C] smiled and said she knew what she 'had to do to get out of here.' She later stated she was upset about a situation that had taken place earlier with a peer who had been taunting her and trying to instigate a fight with her. Staff escorted [client C] to be assessed by the nurse who had treated the cut to her wrist...[Client C's] QSP (Qualified Support Professional) took [client C] to the Emergency Room to have her wrist and abdomen X-rayed since [client C] stated that she had ingested and inserted glass into her arm. X-ray results revealed that [client C] has a foreign object in her right wrist and recommended that she follow up with a hand surgery specialist for removal of the item...Immediate: WTS will continue to keep [client C] in staff sight at all times per her precaution and will follow the behavioral support interventions as outlined in her behavior support plan. Long-Term: [Client C's] IDT (interdisciplinary team) has met and discussed this issue. Per [client C's] request, as well as the recommendation of</p> | | | | | | |

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| | <p>her IDT team, It will be presented at the next human rights committee meeting that [client C] have all items removed from her bedroom. She will be able to access these things with staff assistance so that she can be monitored in order to ensure safety. Behavioral specialists will continue to work with [client C] and staff to identify better ways to cope with her feelings of frustration and anxiety."</p> <p>The facility's 12/27/12 follow-up report indicated client C was placed on Level 1 Suicide Precautions after the 12/18/12 incident occurred. The follow-up report indicated "...[Client C] had been taken off all of her precautions prior to this incident taking place; therefore she was not on any program requiring her to be in staff sight at all times. She was under the care and supervision of staff with 15 minute checks when not in the milieu of the dayroom. Therefore, it is not appropriate to deem this an incident of neglect because staff were implementing appropriate supervision within the guidelines of her psychiatrist. Unfortunately, this situation has proven that this is not an appropriate type of supervision for her at this time and therefore WTS will continue to follow the precaution recommendations of [name of psychiatrist] as well as put other measures in place (removal of personal belongings</p> | | | | | | |

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| | <p>from room) to provide a safe environment for [client C]...." The 12/27/12 follow-up report indicated client C was to see a hand surgeon on 12/28/12 and the client was started on Keflex (antibiotic) 500 milligrams three times a day for 7 days due to the foreign object in the client's wrist/arm. The facility's 12/18/12 reportable incident report and/or 12/27/12 follow-up report neglected to indicate if the facility had conducted an investigation for possible neglect to determine if the facility actually conducted 15 minute checks on client C on 12/27/12, and/or how the checks were conducted due to the amount of injuries client C caused to herself.</p> <p>Client C's record was reviewed on 1/23/13 at 11:26 AM. Client C's 9/17/12 Admission Review Form indicated client C was admitted to the facility on 9/21/12. The 9/17/12 admission form under the section entitled "Special Requirements" indicated "[Client C] has a history of self-harming behaviors, typically during the night & (and) when she is in a quiet room area. She should be closely monitored for scratching/cutting herself with objects & at night for attempting to tie things around her neck." The 9/17/12 form indicated client C "...Self harms by tying things around her neck, scratching herself with broken or sharp objects,</p> | | | | | | |

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| | <p>inserting things into her vagina, banging her head...."</p> <p>Client C's 10/25/12 Behavioral Support Plan (BSP) indicated "...[Client C] has a longstanding mental health history characterized by mood instability, self injurious behavior, suicide attempts, physical aggression, and poor insight and judgement...." The 10/25/12 BSP indicated client C demonstrated self injurious behavior "...can be severe in nature'...Previously required continuous observation between the hours of 9:00p-7:00a [(at name of previous placement)]...." The BSP also indicated client C demonstrated "...Suicidal actions (Referral documents indicate [client C] came 'very close to succeeding 2 X's (times) in the last 4 years'). Broken CD's and inserted them into her 'private areas.'" Client C's 10/25/12 BSP indicated if "... [Client C] is unable/unwilling to use more appropriate coping skills for feeling stressed, upset, or depressed, staff may remind [client C] of the natural consequences of her behavior...For instance the loss of personal items that are deemed potentially dangerous [keys, pens, pencils, etc.] following an incident of self-abuse to ensure her personal safety, as this was previously requested by [client C] at her previous placement...." The 10/25/12 BSP indicated "...IF THE</p> | | | | | | |

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| | <p>CRISIS BEHAVIOR IS SELF-HARM ([client C] is an imminent danger to herself)...1. When a crisis situation occurs with [client C], she will be immediately asked to go to the nearest 'Calm Space' (Isolation) until she can regain control of behavior. A. Whenever an isolation intervention is employed, staff will continuously observe [client C] during the duration of the isolation to ensure her safety, reinforce the appropriate behavior, complete appropriate documentation, and respond immediately to any harmful health or psychological reactions [client C] may experience...."</p> <p>Client C's IDT Notes indicated the following (not all inclusive):</p> <p>-10/29/12 "Placed on level 2 suicide precautions due to statements of 'not feeling safe.' This does not seem to necessitate any precautions beyond her normal bed checks."</p> <p>-11/13/12 Remains on Level 1 suicide precautions."</p> <p>-11/14/12 Remains on Level 1 suicide precautions.</p> <p>-12/19/12 "She was agitated saying her QSP was lying to her because she doesn't</p> | | | |

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| | <p>have her new goals in the binder. She was p (sic) physically aggressive toward staff, hit staff and attempt (sic) to hit peer. Staff placed her in physical restrain (sic) to prevent injury to her self (sic) and others. She was self harm in her room tired (sic) cord round her neck, broken DVD player and have a scratch in her wrist. she (sic) slept in the observation room per the nurse for suicide watch."</p> <p>-12/26/12 "...team discussed removing everything from her room and consistent line of sight due to self harming behaviors."</p> <p>-12/28/12 "[Client C] was removed from suicide precaution; however it is the recommendation of her team that she remain on line of sight precaution continually. She has agreed to have her personal items removed form her bedroom for her safety." Client C's IDT neglected to review the 11/9/12 incident, when it occurred, to ensure proper monitoring and supervision was in place to prevent additional incidents from occurring as client C had a history of self-harm incidents at night, in her bedroom. Even though, the facility removed the client's personal items, the client's BSP neglected to indicate how often client C's bedroom should be swept for items as client C had access to items</p> | | | |

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| | <p>from other areas of the facility to prevent incidents of self harm from occurring. Client C's 12/28/12 IDT note neglected to specifically indicate if client C would be on line of sight precautions at night, in the client's bedroom.</p> <p>Interview with Treatment Team Coordinator (TTC) #1, Behavior Support Coordinator (BSC) #1, QSP #1, #2 and the Health Service Coordinator (HSC) on 1/28/13 at 12:10 PM indicated client C demonstrated behaviors of self harm on 11/9/12 and 12/18/12. QSP #1 and BSC #1 indicated client C had been on continuous monitoring/supervision by staff at her previous placement due to the client's self-injurious behavior. BSC #1 indicated facility staff had been placed at the client's bedroom door, at night, at the client's previous placement. BSC #1 and TSP #1 indicated the client's psychiatrist removed the client from the continuous observation after the client was admitted to the facility as the client did not have any self harm attempts. TTC #2 and QSP #1 and BSC indicated client C was now on line of sight at all times since the 12/18/12 incident. TTC #1, BSC #1 and QSP #1 indicated client C was in line of vision prior to the 12/18/12 incident. TTC #1 then indicated client C was on 15 minute checks which were done with all the clients at WTS. TTC #1 and QSP #1</p> | | | | | | |

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| | <p>indicated client C's 10/12 BSP did not specifically indicate how facility staff were to monitor the client at night when the client was in her bedroom. TTC #1, the HSC, BSC #1 and QSP #1 indicated client C had asked that all the client's belongings be removed from the client's bedroom to prevent self harm incidents. QSP #1 and TTC #1 indicated client C's BSP did not indicate how often facility staff were to sweep the client's bedroom to prevent the client from obtaining/hiding objects retrieved from other parts of the building/facility. TTC #1 indicated the facility did not conduct/document an investigation in regard to allegations of possible neglect in regard to staff monitoring for the 11/9/12 and 12/18/12 self harm incidents. TTC #1 indicated the facility was in the process of changing how they documented their IDT meetings to indicate what was discussed/reviewed and any recommendations/changes made.</p> <p>2. The facility's reportable incident reports, BIRS and/or investigations were reviewed on 1/23/13 at 10:29 AM. The facility's 1/13/13 reportable incident report indicated "On 1-13-2013, it was reported to staff by [client A], individual, that she had sex with her boyfriend, [client I], while in the bathroom of the Canteen room. An internal investigation</p> | | | | | | |

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| | <p>has occurred in which video footage was reviewed and statements were gathered. [Administrative staff #1], Executive Director and [administrative staff #2], Interim Director of Operations discussed the incident with [name of Bureau of Developmental Disability Services (BDDS) staff] on 1-16-13 as there were questions as to whether or not this was a reportable incident. Both individuals consented and neither of them have (sic) a guardian. [Name of BDDS staff] asked that we report the incident and [name of Adult Protections (APS) staff] from APS were also notified verbally. Investigation results were unable to substantiate if sexual intercourse has actually taken place due to a lack of video access to the bathroom. Staff [staff #11], who was monitoring the individuals during their visitation, was suspended and consequently terminated on 1-18 due to poor judgement of allowing these two individuals to spend time together in the restroom, although both were consenting adults and both requested to go into the restroom together."</p> <p>The facility's 1/14 and 1/15/13 Internal Investigation Report indicated "On 1-13-13, [client A and client I] (currently a couple) were in the Canteen room for an evening visit. Staff, [staff #11], was supervising the visit. Upon returning</p> | | | | | | |

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| | <p>from the visit, [client A] stated to staff [staff #12] that she had sex that evening with her boyfriend, [client I] while in the Canteen room bathroom... I asked her where the staff was at, she told me that he (staff #11) was sitting in the chair and that he them permission to go into the bathroom (sic). I explained to [client A] that she should have taken the sex Ed. (education) Classes that I have been talking to her about. She said okay and then she wanted to speak to the nurse about some things. On 1-14-2013, [client I] stated that he asked his staff on the evening of 1-13-2013 if he could go in the bathroom to have sex together (with his girlfriend). He also stated that he did have sex with his girlfriend in the bathroom and that both she and he consented to this act. [Client I] also stated that he did not use protection and has had sexual education training at [name of hospital] 5 weeks prior to admission at Warner Transitional Services. On 1-14-2013, [client A] gave the following statement 'On the evening of January 13, 2013 at approximately 9:00pm, I went to the canteen with my boyfriend, [client I], and his new staff. We were sitting in the canteen talking and listening to music. We were whispering to each other. I told [client I] that WTS is taking too long for the sex education classes. He told me that he can ask his</p> | | | |

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| | new staff that just got out of orientation if we can go into the bathroom for the last 5 minutes of our personal visitation. We talked back and forth with each other for about 5 minutes trying to figure out who should be the one to ask the staff. Finally I spoke up. I asked him [the staff] if we could go in the bathroom alone for 5 minutes. The staff asked us if we were our own guardians. We said yes. Then he asked us if it was in our programs. We said yes; but we were lying. The staff then saluted and said 'Go ahead. Let me know when you are done.' We had sex while we were in the bathroom...." The facility's investigation indicated the clients did not use any protection and they both indicated they had sexual intercourse. The facility's 1/14 and 1/15/13 investigation indicated "...Upon returning back to the unit, I (client A) noticed that I had vaginal bleeding. The nurse was notified and examined my private area. She also provided me with information on sexually transmitted diseases. Also on 1-14-12013, when asked, [client A] stated that she has had sexual education training three times prior to coming to Warner Transitional Services...." The facility's investigation indicated staff #11 admitted to allowing the clients to go into the bathroom for private time together. Staff #11's 1/13/13 witness statement indicated staff #11 was | | | | |

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| | <p>to "monitor" clients A and I in the canteen area. Staff #11's witness statement indicated clients A and I were in the bathroom for 10 to 15 minutes. The facility's investigation indicated the facility's videotape indicated the clients were in the bathroom alone for 18 minutes and "...All clients should be supervised at least every 15 minutes...." The facility's "...Conclusion: [Clients I and A] both entered the Canteen bathroom together. Due to the fact that there is no video access in the bathroom, it could not be concretely substantiated that the two individuals had intercourse. [Staff #11], staff, exercised poor judgement in allowing this action to take place due to a lack of knowledge of the appropriate way to handle this situation that arose. Staff [staff #11] did not seek information from the correct source as he sought information from the clients themselves as opposed to referring to their support plans or his supervisor. Actions(s) Taken: Staff, [staff #11], who was monitoring the individuals during their visitation, was suspended and recommendation is termination due to poor judgement leading to poor supervision."</p> <p>Client I's 1/14/13 WTS Behavioral Report Continuation Form (witness statement) indicated client I had an "orgasm" inside</p> | | | | | | |

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| | <p>client A. The witness statement indicated "What did she say afterwards?" She asked me (client I) to get up off of her." The 1/14/13 witness statement indicated he consented to having sex with client A and was worried he (client I) would get in trouble for what he did.</p> <p>Client A's 1/14/13 typed witness statement indicated client I did not use a condom when they had sex. An attached undated typed question and answer statement of client A with QSP #2 indicated clients A and I had "intentionally violated the boundaries of your relationship (kissing and holding hands)." The typed statement indicated the boundaries were set by the clients and their IDT. The typed statement also indicated client A had, at times, refused to take her birth control pills.</p> <p>The facility's recorded/audio tape was reviewed on 1/23/13 at 3:35 PM. The video/audio tape was of clients A and I and staff #11 in the Canteen room of the facility at 9:46 PM on 1/13/13. The video/audio tape indicated music was playing in the canteen which prevented clients A and I's conversation from being heard. The video tape did indicate the clients were sitting in one area of the canteen and staff #11 was on the other side of the room looking at a magazine.</p> | | | | |

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| | <p>Clients A and I could be seen talking/whispering to each other and looking over to staff. At 9:52 PM, the video indicated the clients cut the music off. The video indicated client A asked staff if they could spend the last 5 minutes of their visitation in the bathroom of the Canteen. The video/audio tape showed staff #11 asked clients A and B if this was in their program. The video/audio tape indicated both clients stated "Yes." Staff #11 saluted clients A and I and both clients walked into the Canteen bathroom and closed the bathroom door. Staff #11 sat in the Canteen room whistling, stood whistling and walked out of sight of the camera at 9:57 AM at the door/entrance of the Canteen Room. Staff #11 could still be heard whistling even the staff could not be seen. Staff #11 then stated to the clients in the bathroom, "It is a little after 10." Client A responded "Ok." Client A could be heard moaning/making sounds, in the Canteen bathroom, with the door closed. At 10:04 PM, staff #11 stated "You got to wrap it up. Wrap it up." Client A again could be heard moaning and making sounds in the Canteen bathroom. At 10:07 PM, staff #11 stated "We got to roll. We got to roll." At 10:09 PM, Clients A and I came out of the bathroom dressed with client A trying to straighten out her hair with her hand. Clients A and I retrieved their</p> | | | | |

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| | <p>items from the table and began to walk out of the Canteen room.</p> <p>The facility's 1/14 and 1/15/13 investigation indicated the facility neglected to conduct a thorough investigation in regard to the above incident. The facility neglected to substantiate clients A and I had sexual intercourse in the bathroom even though both clients indicated they had sexual intercourse, and by hearing moaning/sounds from the bathroom of the facility's video and audio surveillance. The facility's investigation neglected to interview any medical staff/nurse in regard to the client's vaginal bleeding, and neglected to interview any additional staff and/or clients at the facility to determine if this type of incident/practice had occurred before with any other clients and/or staff. The facility's investigation neglected to include any recommendations and/or corrective actions to prevent similar incidents in the future.</p> <p>Client I's record was reviewed on 01/24/13 at 11:06 AM. Client I's record contained the following information: 08/20/12: Admitted to facility. 09/10/12: ISP (Individual Support Plan) indicated, "Sexuality Awareness: [Client</p> | | | | | | |

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| | <p>I] requires supervision to remain safe in sexual situations. He has not demonstrated that he understands who can give consent and has difficulty discriminating between children and adults. Reports indicate his inability 'to control his sexual urges.' [Client I] has extensive history of sexually inappropriate behaviors, and has a current psychiatric diagnosis of Pedophilia. It was also noted he was previously arrested and charged with 2 counts of child molestation in October 2005."</p> <p>09/10/12: BSP (Behavior Support Plan) indicated client I's behaviors included, but were not limited to: manipulating behavior, verbal aggression, physical aggression, hostility, inappropriate touching and sexual aggression. Client I's diagnoses included but were not limited to: Mild Mental Retardation, Pedophilia and Impulse Control Disorder. The BSP indicated, "Additionally, it was reported [client I] has stated on more than one occasion, he cannot distinguish between children and adults because although the faces of child (sic) look younger, 'there is not much difference in their bodies' ...It</p> | | | |

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| | <p>was also reported he would continually touch the individual regardless of whether the person consented to his advances or not ...also noted he appeared to refuse the idea that others are not sexually attracted to him and is unable to control his state of arousal."</p> <p>01/2013: ISP Goal Documentation Sheet indicated, "[Client I] will increase his knowledge of rights and responsibilities associated with sexuality. The purpose of this program is to assist [client I] in improving his capacity for independent living by increasing his recognition of rights and responsibilities associated with appropriate sexual relationships. The staff need to ask [client I] the following questions: 1) Do you have the right to not be touched if you don't wish to be?, 2) Name at least 3 forms of birth control (answers can include but are not limited to: condoms, birth control pills, abstinence, diaphragms), 3) What is the appropriate age of a consulting adult to be able to have sex?"</p> <p>01/14/13: Team Meeting Summary document indicated, "Reason For</p> | | | | | | |

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| | <p>Meeting: Individuals have allegedly had sex in the bathroom. An investigation is taking place. Both parties consented."</p> <p>Client I's record indicated the facility neglected to meet prior to the 1/13/13 incident to outline any specific guidelines, in regard to his relationship with client A, to ensure the protection of both clients.</p> <p>Client A's record was reviewed on 1/23/13 at 5:00 PM. Client A's Daily Progress Notes indicated clients A and I had visitation with each other on 1/2/13, 1/7/13, 1/12/13 and on 1/13/13. The 1/13/13 note indicated "...Upon return from her visit she alleged that staff allowed her and [client I] into a bathroom by themselves where she and [client I] had intercourse which resulted in [client I] ejaculating inside of her (sic)...."</p> <p>Client A's Nursing Progress Notes from 1/1/13 to 1/21/13 neglected to indicate any documentation in regard to medication refusals of the client's birth control pills. The Nursing Progress Notes also indicated the facility neglected to document an assessment of client A in regard to the vaginal bleeding and/or to obtain a physical assessment of the client due to the nature of the incident.</p> | | | | | | |

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| | <p>Client A's 1/17/13 faxed order indicated client A's doctor ordered a blood pregnancy test on 1/17/13. The faxed order indicated a second test was to be conducted in another 24 hours to rule out client A being pregnant. On 1/23/13, client A's record neglected to indicate any documentation and/or results in regard to the blood pregnancy test.</p> <p>Client A's January 2013 Medication Administration Record (MAR) indicated client A received Nortrel 7-7-7-28 1 tablet daily for birth control. The 1/13 MAR indicated client A refused to take her birth control pill on 1/14 and on 1/18/13.</p> <p>Client A's record and/or IDT notes from 11/12 to 1/13 indicated the facility neglected to document any discussion of client A and I's relationship in regard to "boundaries" prior to the 1/13/13 incident. Client A's 1/14/13 Team Meeting Summary indicated "It was reported by [client A] that she and peer, [client I], had intercourse last night. Team is meeting to discuss what follow-up actions need to be taken...IDT discussed that they (IDT) think [client A] is intentionally trying to get pregnant...." The IDT note indicated client A and I's visitation would "...temporarily be suspended pending the investigation." The 1/14/13 IDT note also</p> | | | | | | |

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| | <p>indicated the nurse would review the client's MAR to see often client A had refused her birth control pills, obtain a pregnancy test and talk to client A about unprotected sex. The IDT note also indicated "... (6) QSP will reinforce to staff that WTS is a 24 hour supervision facility and that 2 peers of opposite sex are never to be left unattended out of staff's sight for any reason without the appropriate consent from authorized parties (i.e. QSP, TTC)." The IDT note indicated the facility did not have client A attend and/or participate in the IDT meeting.</p> <p>Client A's 12/12 Individual Support Plan (ISP) indicated client A was her own guardian but client A had a health care representative. Client A's 1/11/13 Behavior Support Plan (BSP) indicated the client had a targeted behavior of program refusals/noncompliance which included refusals of medication. Client A's 1/11/13 BSP and/or ISP neglected to include specific guidelines, and/or specifically indicate what staff were to do when the client refused her medications/birth control pills. Also client A's ISP indicated the facility neglected to address and/or include formal training in regard to the sexuality/relationships as client A's ISP did not indicate the client was in a sexual</p> | | | | | | |

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| | <p>education/class.</p> <p>The facility's policy and procedures were reviewed on 1/22/13 at 3:00 PM and on 1/23/13 at 5:12 PM. The facility's policy and procedures indicated the facility neglected to develop a policy and procedure which addressed sexuality and/or sexual activity between clients.</p> <p>Interview with client A on 1/22/13 at 4:00 PM indicated client A and client I had sex on the bathroom floor in the Canteen room. Client A indicated they asked facility staff for permission to have private time in the bathroom. Client A stated the staff said "Yes." Client A stated the facility staff "saluted them." Client A indicated she felt she may be pregnant as she had missed some of her birth control pills. Client A indicated a pregnancy test had been done. Client A indicated before she and client I could have sex, the facility indicated they would have to complete a sex education class. When asked if the client was in a sex education class, client A stated "No. Still don't have class."</p> <p>Interview with TTC #1 and #2 on 1/23/13 at 3:00 PM indicated sounds could be heard coming from the bathroom during the 1/13/13 incident upon review of the audio tape. TTC #1</p> | | | | |

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| | <p>indicated the facility could not substantiate clients A and I had sexual intercourse as it could not be seen what happened in the bathroom.</p> <p>Interview with administrative staff #2 on 1/23/13 at 5:15 PM indicated the facility did not have a policy and procedure regarding client to client relationships/sex at the facility. Administrative staff #2 indicated since the incident, the facility was in the process of developing a policy. Administrative staff #2 stated the facility had a "Draft."</p> <p>Interview with HSC #1, QSP #2 and TTC #1 on 1/28/13 at 12:10 PM, indicated clients A and I were boyfriend and girlfriend. TTC #1 and QSP #1 indicated facility staff allowed clients A and I to go into the bathroom together. TTC #1 indicated the facility did not substantiate intercourse had taken place with clients A and I as there were no cameras in the bathroom. TTC #1 and QSP #2 indicated client A was not involved in sexuality training as the men were currently receiving the training and the facility wanted to keep the men and women's training separate. HSC #1 indicated she was not sure if a nurse assessed client A after the allegation was made. HSC #1 indicated she was not</p> | | | |
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| | <p>aware of the vaginal bleeding as she was not at the facility at that time. HSC #1 indicated if there was an assessment, nursing staff should have documented the assessment. QSP #2 indicated she spoke with facility staff to remind them clients needed to be supervised at all times. QSP #2 indicated she neglected to document her re-training with staff. TTC #1 and QSP #2 indicated clients A and I had not been allowed to have sex in the past. QSP #2 and HSC #1 indicated client A's pregnancy tests indicated the client was not pregnant. QSP #2 and HSC #1 indicated the facility was in the process of changing the client to Depo Provera shots versus pills due to her refusals. QSP #2 indicated the client's IDT had set up boundaries with the clients. QSP #2 indicated the clients were allowed to hold hands and kiss while on visitation. QSP #2 indicated this was discussed, but did not provide documentation the IDT reviewed/discussed.</p> <p>Interview with HSC #1 on 1/28/13 at 4:40 PM indicated client A had 3 medication refusals in January 2013. HSC #1 indicated when client A refused her birth control medications they doubled up the pills the next day.</p> <p>Interview with Safety and Security</p> | | | | | | |

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| | <p>Professional (SSP) #1 and administrative staff #2 on 1/23/13 at 3:45 PM indicated staff #11 had a walkie talkie and phone in the Canteen. SSP #1 and administrative staff #2 indicated the staff should have called someone before allowing the clients to go into the bathroom. Administrative staff #2 indicated staff #11 was no longer employed by WTS.</p> <p>Interview with administrative staff #1 on 1/28/13 at 3:59 PM indicated no additional interviews were conducted in regard to the investigation. Administrative staff #1 indicated it could not be substantiated clients A and I had sexual intercourse as there was no camera in the bathroom. Administrative staff #1 indicated staff #11 was terminated. Administrative staff stated they (administrative staff) were "shocked" when they reviewed the video.</p> <p>3. The facility's reportable incident reports and/or investigations were reviewed on 1/23/13 at 10:29 AM. The facility's 1/8/13 reportable incident report indicated client F had an appointment at a government office where the client was in a good mood. The 1/8/13 reportable incident report indicated "...While on the ride home, at approximately 2:20 pm, [client F] had made up an elaborate, detailed story of her social history stating</p> | | | | | | |

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| | <p>that she was adopted and that her late maternal grandmother was her 'real' mother...When we were about 10 minutes away from returning to the WTS facility, the QSP looked over and saw that [client F's] entire affect had changed. She was visibly agitated for an unknown reason. QSP asked [client F] if she was okay, and [client F] responded with vulgar profanity and said she did not want to talk to her QSP. QSP replied that's okay and that we're almost back so she can have some private time when we get there to help relieve some of her anxiety. When the vehicle was about 5 minutes away from the facility, [client F] took her family photos out of her purse and started ripping her photo into many little pieces. Then she took a CD case and started to break the case. QSP removed the CD case from [client F] for fear that [client F] was going to harm herself with it. Immediately [client F] became physically aggressive towards her QSP (who was driving) and was continuously throwing punches to the QSP's face and right arm. QSP was able to block most of the hits with her right arm and pushed [client F] off of her. QSP informed [client F] that she was driving and that it was not safe for either one of them. In turn, [client F] tried to pull the shifter out of gear while the vehicle was in motion. Once again, QSP</p> | | | |

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| | <p>reminded [client F] that it was not safe to do that and that they were almost back to the facility. While they were on [name of busy street], less than a mile from WTS, [client F] reached over and pulled the entire steering wheel towards the passenger side which caused the vehicle to swerve into the other lane of traffic. There were no cars in that lane at that time. QSP attempted to call WTS for assistance to come outside to help when they arrived, but [client F] began hitting the QSP again and then opened the passenger side door. She leaned out of the door, however she had her seatbelt on as a restraint. QSP had grabbed on to her jacket and pulled her back into the vehicle. She tried to take off her seatbelt, but QSP held it in the socket with the right hand and continued to steer the vehicle with the left hand. [Client F] had climbed out of her seatbelt. QSP made the call at that point to bring the vehicle to a stop since [client F] was no longer secured in the car. [Client F] opened the door and jumped out of the vehicle while it was still in motion. The QSP got out of the car and yelled for [client F] who was running down the middle of [name of busy street] towards oncoming traffic. At 2:28 pm, the QSP had WTS on the phone at this time to send out emergency assistance to help retrieve [client F]. Two DSPs (Direct Support</p> | | | |
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| | <p>Professionals) and a LDSP (Lead Direct Support Professional) joined the QSP within 2 minutes and they drove south on [name of busy street] towards the direction [client F] had eloped. A car on the opposite side of the road had flagged down the vehicle. An off-duty staff that works on the hall with [client F] was coincidentally driving down the same street with her mother on the way to the grocery store when she had seen [client F] running. She pulled over and [client F] voluntarily got in her car. QSP and other staff pulled up to the vehicle. [Client F] was sitting in the backseat crying. (She had also broken her glasses while she was running.) Later in the evening, [client F] was describing the events of the day to a Safety and Security Professional and [client F] kept referring to the incident as 'Happy feet'...Immediate: There is an emergency IDT meeting scheduled for [client F] on Thursday January 10, 2013 to discuss this event and make revisions as deemed necessary to her Behavior Support Plan. [Client F's] guardians will be participating via phone conference. Long-Term: WTS administration will meet to discuss possible revisions to the agency policy regarding client transports." The facility's 1/8/13 reportable incident report indicated the facility neglected to conduct and/or</p> | | | | | | |

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| | <p>provide evidence of an investigation for possible neglect in regard to staff monitoring/supervision, and/or indicate how client F broke her glasses during the 1/8/13 elopement incident.</p> <p>Client F's record was reviewed on 1/25/13 at 1:45 PM. Client F's 11/26/12 Transitional Behavioral Support Plan (TBSP) indicated client F was admitted to the facility on 11/26/12. The 11/26/12 TBSP indicated client F demonstrated the targeted behavior of elopement which was defined as "...Leaving designated area or staff supervision without permission. Previous placement reports that [client F] enjoys going to the doctor and will often NOT elope during doctor appointment outings, but must be closely supervised on all other outings. [Client F] has a history of attempting to manipulate staff to create an opportunity to elope. Last incident of attempted elopement was in March 2012...."</p> <p>Client F's 1/2/13 Behavior Support Plan (BSP) Level 1 "Proactive or Preventative Strategies" section indicated "...5. Due to [client F's] history of elopement, impulsiveness, and self-harming behaviors, supervision requirements necessary for her to participate in community activities and off-ground activities include she is to be within line</p> | | | | |

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| | <p>of sight and arm's reach of staff at all times. To reduce elopement while on community outings, [client F] will be transported by one staff who is designated as the driver and another staff who will monitor [client F]. [Client F] will sit in the back seat of the vehicle and will not sit behind the driver of the vehicle. Last documented incident of elopement was in March 2012...."</p> <p>An attached BSP addendum to the 1/2/13 BSP dated 1/11/2013 indicated "[Client F] has the potential to elope while on community outings, and had an incident of elopement on 1/8/2013. Since she acts in an impulsive manner, she places herself in a situation which could cause serious injury to herself and others. For three months, [client F] will only leave the facility for necessary medical appointments. During this period, [client F] will be transported by two staff. A third staff will act as the driver. [Client F] will only sit in the back of the vehicle in a seat that is not directly behind the driver. After three months, [client F's] IDT will evaluate if it is appropriate for her to leave the facility for programming activities, such as shopping with her Life Skills instructor. After six months, [client F's] IDT will evaluate the appropriateness of restoring full privileges allowing [client F] to</p> | | | | | | |

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| | <p>participate in community outings with appropriate staff supervision...."</p> <p>The facility neglected to implement/follow client F's 1/2/13 BSP in regard to sending 2 staff, during transport with client F, to the scheduled appointment in the community which resulted in client F placing herself and staff in danger in the van, and in regard to client F's elopement from a moving vehicle. The facility neglected to monitor/supervise client F adequately in the community which resulted in client F's being disciplined/restricted from community outings/activities.</p> <p>Interview with client F's guardian on 1/28/13 at 8:16 AM indicated client F had a history of elopement.</p> <p>Interview with QSP #2, TTC #1 and BSC #1 on 1/28/13 at 12:10 PM indicated client F had a history of elopement. QSP #2 indicated she was with client F on 1/8/13 when the incident occurred. QSP #2 indicated she was the only staff in the van with client F. QSP #2 indicated client F did fine until they were returning from the facility from her appointment in the community. QSP #2 stated "Within 30 seconds demeanor and affect changed. Can't say what triggered her." QSP #2 stated client F turned the volume up in</p> | | | |
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| | <p>the van, ripped her pictures she had in her purse, hit QSP #2, "busted" a CD case and hit QSP #2 with a purse. QSP #2 stated she did not stop and/or pull over as she knew client F was "an elopement risk." QSP #2 stated client F "turned wheel (steering) into traffic" and opened the vehicle door. QSP #2 indicated client F eloped from the vehicle and ran down the street where an off duty staff saw/found the client. QSP #2 stated at the IDT meeting, "She (client F) had no awareness or concern at meeting" in regard to what she had done on 1/8/13. When asked how client F's restrictions came about, QSP #2 stated client F's "Getting out of vehicle to do that was a safety risk of going out into traffic." TTC #1 and QSP #2 indicated staff #13 found client F on 1/18/13 after the client eloped from the vehicle as staff #13 was driving with staff #13's mother to go to the store. TTC #1 indicated no investigation had been conducted/documentated in regard to the 1/8/13 incident. When asked how client F broke her glasses, QSP #2 stated "She threw them." QSP #2 indicated client F broke her glasses after she eloped from the van. QSP #2 indicated client F's IDT neglected to meet prior to client F going out in the community with one staff supervision/monitoring.</p> | | | |
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| | <p>The facility's policy and procedures were reviewed on 1/23/13 at 3:00 PM and at 5:12 PM. The facility's 8/12 revised policy entitled Reporting and Investigations indicated "It is the policy of Warner Transitional Services (WTS) to protect individuals who may be vulnerable to abuse, neglect or exploitation, mistreatment, or a violation of client rights...." The policy indicated "...If an allegation of abuse or neglect is made, the Qualified Support Professional (QSP) or Safety/Security Professional (SSP) will ensure the individual is moved to a safe location. The QSP or SSP will notify all appropriate WTS staff including the Executive Director/Administrator who is responsible for ensuring that all investigations are completed thoroughly and that records of the investigation are maintained...." The facility's June 2012 policy entitled Employee Conduct indicated "Each person receiving services from WTS will receive humane care and protection from harm...." The policy indicated clients had the right to be free from neglect and/or punishment.</p> <p>4. The facility's BDDS Reports were reviewed on 01/24/13 at 12:08 PM. The 50 reports indicated the following dates of reportable incidents which included but were not limited to self harm, property</p> | | | | | | |

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| | <p>destruction, peer to peer aggression, physical restrains and PRN medications for behavior, involving clients B, D, G, H, I, R and U from 11/01/12 to 01/22/13.</p> <p>Client B: 5 BDDS reports of aggressive behaviors requiring physical restraints on: 11/26/12, 11/27/12, 12/03/12, 12/26/12 and 01/02/13.</p> <p>Client B: 5 BDDS reports of client B to client (unidentified) aggression requiring PRTs (Primary Restraint Techniques) on 11/26/12, 12/14,12, 12/22/12, 01/17/13 and 01/22/13.</p> <p>Client B: There were no BDDS reports for the 5 aggressive behaviors which occurred and PRTS were used on: 11/27/12, 12/10/12, 12/2/12, 01/9/13 and 01/12/13 per client B's BIRs.</p> <p>Client D: 1 BDDS report of aggressive behaviors requiring physical restraints on: 01/09/13.</p> <p>Client D: 2 BDDS reports of client D to client (unidentified) aggression requiring PRTs on 11/16/12 and 12/09/12.</p> <p>Client D: There were no BDDS reports for the 4 aggressive behaviors which occurred and PRTs were used on: 12/09/12, 12/10/12, 01/09/13 and</p> | | | | | | |

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| | <p>01/09/13 (2nd episode) per client D's BIRs.</p> <p>Client G: 13 BDDS reports of self harm on: 11/10/12, 11/16/12, 11/18/12, 11/27/12, 12/12/12, 12/17/12, 12/17/12 (second incident), 12/21/12, 12/30/12, 01/01/13, 01/05,13, 01/18/13 and 01/19/13.</p> <p>Client G: 1 BDDS report of PRN medication for behaviors reported on 12/02/12.</p> <p>Client G: 1 BDDS report of client G to client (unidentified) aggression on 01/19/13.</p> <p>Client G: There were no BDDS reports for the 9 aggressive behaviors which occurred and PRTs were used on: 11/16/12, 11/18/12, 11/22/12, 11/24/12 (2nd episode), 12/12/12, 12/16/12, 12/17/12, 12/22/12 and 01/18/13 per client G's BIRs.</p> <p>Client H: 2 BDDS reports of self harm on: 11/18/12, 11/18/12 (2nd episode).</p> <p>Client H: 7 BDDS reports of aggressive behaviors requiring physical restraints on: 11/16/12, 11/21/12, 11/26/12, 11/29/12, 11/28/12, 11/30/12 and 12/31/12.</p> | | | | |

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| | <p>Client H: 1 BDDS report of PRN medication for behaviors reported on 12/18/12.</p> <p>Client H: 2 BDDS reports of client H to client (unidentified) aggression on 11/27/12 and 12/23/12 (client K).</p> <p>Client H: There were no BDDS reports for the 13 aggressive behaviors which occurred and PRTs were used on: 11/16/12, 11/19/12, 11/19/12 (2nd episode), 11/27/12, 11/30/12, 12/10/12, 12/10/12 (2nd episode), 12/10/12 (3rd episode), 12/27/12, 12/28/12, 12/30/12, 12/31/12 and 01/02/13 per client H's BIRs.</p> <p>Client R: 1 BDDS report of aggressive behaviors requiring physical restraints on: 11/17/12. The aggressive behavior resulted in injury to staff #10's left thumb which was broken and surgery was required to repair.</p> <p>Client R: 2 BDDS reports of client R to client (unidentified) aggression on 12/16/12 and 01/05/13 (client G).</p> <p>Client R: 6 BDDS reports of aggressive behaviors requiring physical restraints on: 11/09/12, 11/09/12 (2nd episode), 11/17/12, 11/29/12, 12/06/12 and 01/05/13.</p> | | | | |

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| | <p>Client U: 1 BDDS report of aggressive behaviors requiring physical restraints on: 11/30/12. The aggressive behavior resulted in injury to staff #28's left little finger which was dislocated and medical treatment was required to realign the finger.</p> <p>The facility's reportable incident reports, Behavior Report Incidents (BIR) and/or investigations were reviewed on 01/22/13 at 11:30 AM, 01/23/13 at 9:30 AM, 01/24/13 at 10:00 AM, on 01/25/13 at 1:15 PM and on 01/28/13 at 11:12 AM. The facility's reportable incident reports, BIRs and/or investigations indicated the following aggressive behaviors occurred since 11/01/12 (not all inclusive):</p> <p>Client B's records were reviewed on 01/24/13 at 4:13 PM. Client B's record contained the following information related to client B's aggressive behavior:</p> <p>11/09/12: Client B admitted to facility. Transition Behavior Support Plan (TBSP) indicated client B's behaviors included, but were not limited to: physical aggression, self-harming behavior, verbal aggression, ineffective joining behavior (including but not limited to: lying,</p> | | | | |

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| | <p>seeking attention, disrespecting personal boundaries and telling staff repeatedly how to do their jobs), sexual aggression, trafficking (trading personal items with anyone who works at or lives within the facility, or having items on his person that do not 'belong' to him) and elopement. Client B's diagnoses included, but were not limited to: Mild Mental Retardation, Narcissistic Personality Disorder, Histrionic Personality Disorder, Anti-Social Personality Disorder, Impulse Control Disorder, Neglect of child (victim), Physical abuse of child (victim) and Sexual abuse of child (victim).</p> <p>12/04/12: BSP (Behavior Support Plan) included psychiatric medications and restraint techniques for control of client B's behaviors.</p> <p>Behavior Incident Reports indicated client B had 18 behaviors on the following dates:</p> <p>11/26/12: punched peer (client D) in right arm - required PRT.</p> <p>11/27/12: flipped table, threw chairs, knocked cable box over, threats to hit peers and staff, broke glass on fire exit door - aggressive behavior required PRT.</p> | | | |

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| | <p>11/27/12: Peer to peer aggression required PRT.</p> <p>12/03/12: kicked staff, yelling "b...." "I'm gonna bust you in the head b...." Tried to cut wrist with broken radio antenna after tearing up his radio. Client to staff aggression required 6 episodes of PRTs.</p> <p>12/10/12: punched peer (client D) in mouth.</p> <p>12/12/12: smacked peer (unidentified) in mouth with shoe, threw shoe and cards at staff. Yelling "b...." and "I'm gonna bust your head."</p> <p>12/14/12: Aggressive behavior - hit roommate and required PRT.</p> <p>12/21/12: attempted to throw items at peer (unidentified) - aggressive behavior required 2 episodes of PRTs.</p> <p>12/26/12: yelling - charged at staff with pen, threats to staff, threatened to kill self. Aggressive behavior required 2 episodes of PRTs.</p> <p>01/02/13: yelling, pulled metal piece and phone off the wall, tried to throw metal piece, yelling "b....," "I'm gonna bust your head" and "I m gonna f ...a female staff up." Aggressive behavior required PRT.</p> <p>01/12/13: Kicked peer in butt.</p> | | | |

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| | <p>01/17/13: Allegation of sexually touching a peer. Argument with roommate escalated to point of physical fight.</p> <p>01/09/13: Aggressive behavior required PRT.</p> <p>01/12/13: Broke light in hallway, hitting and kicking walls, yelling, verbal threats to unit peers and staff, threatened to kill one staff, then ran to phone and called the police who responded to his call and came to the facility.</p> <p>01/21/13: Stealing items from another client.</p> <p>01/21/13: Refusal of program. Not following of directions.</p> <p>01/22/13: Peer to peer aggression required PRT.</p> <p>Of 18 incidents of aggressive behavior, 10 of the incidents required PRTs.</p> <p>IDT (Interdisciplinary Team) notes dated 11/13/12 through 12/27/12 mentioned an incident of 11/28/12 where he became aggressive toward peer (client D) and "proceeded to toss the dayroom and attempted to rip the cabinet off the wall; exited the hall and busted the window on the fire exit door - was placed in a PRT during second shift. Sustained cut to</p> | | | | | | |

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| | <p>hand when window broke, was seen by nurse." 12/04/12 IDT note indicated client B stole money from client G and "became agitated over time escalated - 2 separate PRT's for self harm and Physical aggression toward staff." IDT notes did not mention that most of the behaviors which resulted in PRTs or a plan on specifically how staff were to deal with the behaviors of client B to prevent reoccurrence.</p> <p>Client D's records were reviewed on 01/24/13 at 3:24 PM. Client D's record contained the following information related to client D's aggressive behavior:</p> <p>08/20/12: Client D admitted to facility. Transition Behavior Support Plan (TBSP) indicated client D's behaviors included, but were not limited to: history of elopement, inappropriate touching/personal boundaries, physical aggression and verbal aggression. Client D's diagnoses included, but were not limited to: Mild Mental Retardation, Mood Disorder, Personality Changes secondary to Meningitis, and Antisocial Personality Disorder.</p> | | | | |

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| | <p>09/10/12: BSP (Behavior Support Plan) included psychiatric medications and restraint techniques for control of client D's behaviors.</p> <p>Behavior Incident Reports indicated client D had 10 documented behaviors from 11/16/12 to 01/21/13 on the following dates:</p> <p>11/16/12: client D aggressive to peer (unidentified) - required PRT.</p> <p>12/09/12: spitting at staff, hit 2 staff in the face, verbally threatening staff - required PRT.</p> <p>12/09/12: aggressive behavior required PRT.</p> <p>12/10/12: hit peer (client G) in the nose - required PRT.</p> <p>01/09/13: hitting at staff, kicking at staff, yelling - required PRT.</p> <p>01/09/13: client to staff aggression - required PRT.</p> <p>01/09/13: punched staff, yelling - required PRT.</p> <p>01/21/13: irritating behavior, yelling, invading personal spaces staff and peers, verbal aggression to peers, "f ... your mom" and "b...."</p> <p>01/21/13: stole pop from peer (client K), opened and drank the pop.</p> | | | | | | |

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| | <p>01/21/13: refusal of programs, not following of directions, not wanting to get up, sleeping in room. Of the 10 behaviors, 7 required PRTs.</p> <p>IDT (Interdisciplinary Team) notes dated 11/07/12 through 12/11/12 neglected to mention the behavior and a plan on specifically how staff are to deal with the behaviors of client D to prevent reoccurrence.</p> <p>Client G's records were reviewed on 01/24/13 at 2:31 PM. Client G's record contained the following information related to client G's aggressive behavior: 10/02/12: Client G admitted to facility. Transition Behavior Support Plan (TBSP) indicated client G's behaviors included, but were not limited to: physical aggression, property destruction, self-abuse/SIB (self-injurious behavior), verbal aggression/threatening/intimidating, program refusal/non-compliance and sexually inappropriate behavior. Client G's diagnoses included, but were not limited to: Mild Mental Retardation, Anti-Social Personality Disorder,</p> | | | |

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| | <p>Anemia, Poor Vision, Neuromuscular Dysfunction and Wheelchair Bound.</p> <p>10/23/12: BSP (Behavior Support Plan) included psychiatric medications and restraint techniques for control of client G's behaviors.</p> <p>Behavior Incident Reports indicated client G had 62 documented behaviors from 11/10/12 to 01/20/13 on the following dates:</p> <p>11/10/12: hit staff. 11/12/12: hitting hands on walls. 11/12/12: kicked peer (client D). 11/14/12: punched staff in face with closed fist. 11/14/16: punched wall/spit on staff. 11/16/12: punched wall/pinched staff - required PRT. 11/16/12: pinched staff/spit at staff. 11/16/12: threw chairs and spit on staff. 11/16/12: hit elbows on chair/opened up old scars on both hands- required PRT. 11/18/12: hit, kicked staff. 11/18/12: spit on staff - required PRT. 11/18/12: punched staff, spit, kicked staff - required PRT. 11/22/12: hit peer (client D).</p> | | | | | | |

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| | <p>11/23/12: spit on staff.</p> <p>11/23/12: punched staff.</p> <p>11/24/12: punched door, spit on staff - required PRT.</p> <p>11/24/12: aggressive behavior - required PRT.</p> <p>11/27/12: hit staff.</p> <p>11/27/12: threw chairs, punched walls - required PRT.</p> <p>11/29/12: hit, kicked, spit on multiple staff.</p> <p>11/29/12: punched staff in stomach and spit on staff.</p> <p>11/29/12: kicked, spit and punched staff.</p> <p>11/29/12: kicked, spit and punched staff.</p> <p>11/29/12: punched staff in nose.</p> <p>12/01/12: kicked, spit on staff, hit staff and peers.</p> <p>12/01/12: pulled penis out of pants to show staff and peers.</p> <p>12/01/12: kicking, spitting, head banging, calling peers and staff on unit "mother-f ... " and yelling, "suck my d...."</p> <p>12/02/12: hit staff.</p> <p>12/02/12: kicking, hitting staff - required PRN medication - required PRT.</p> <p>12/04/12: kicking, hitting staff.</p> <p>12/12/12: kicking, hitting staff, banging hands till they bleed - required PRT.</p> | | | | | | |

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| | <p>12/12/12: kicking, hitting, spitting on staff - required PRT.</p> <p>12/12/12: kicking, hitting, spitting on staff, banging head and cussing - required PRT.</p> <p>12/13/12: kicking, hitting staff.</p> <p>12/16/12: spitting on staff, calling staff and peers "black mother-f ..." - required PRT.</p> <p>12/16/12: hitting arm on chair, grabbing staff breasts - required PRT.</p> <p>12/17/12: hitting, spitting, kicking, threw hot coffee on staff.</p> <p>12/17/12: picking at scabs, hitting wrists, yelling "f ...you" to staff and peers.</p> <p>12/17/12: kicking, hitting staff - required PRT.</p> <p>12/17/12: hitting, kicking spitting on staff - required PRT.</p> <p>12/21/12: hitting peers - banging head and yelling.</p> <p>12/22/12: kicking, spitting on staff and banging head.</p> <p>12/22/12: hitting peer and staff - required PRT.</p> <p>12/30/12: kicking, hitting peer - hitting head - required PRT.</p> <p>01/01/13: scratched face, spitting on staff - required PRT.</p> | | | | |

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| | <p>01/01/13: spitting, kicking staff .</p> <p>01/03/12: spitting, kicking, hitting staff, banging head on wall, yelling, cussing.</p> <p>01/03/12: tried to knock TV over, kicking, spitting and hitting staff.</p> <p>01/05/13: hit peers, kicking staff, hitting his wheelchair, yelling "F ...B...." - required PRT.</p> <p>01/07/13: cussing, choking self.</p> <p>01/08/13: kicking, hitting, spitting on peer, choking self, yelling.</p> <p>01/09/13: kicking, hitting peers and staff, picking old scabs open.</p> <p>01/09/13: kicking, hitting, spitting on staff and yelling.</p> <p>01/12/13: kicking, hitting, spitting on staff.</p> <p>01/16/13: hitting, kicking staff, scratching his face and yelling "Black F..." "Black-A...."</p> <p>01/18/13: kicking peers from wheelchair - required PRT.</p> <p>01/18/13: kicked staff, yelling "play with my d..." "suck my d..." - required PRT.</p> <p>01/18/13: scratched face, grabbed staffs "privates." Yelling "suck my d... for some cookies." - required PRT.</p> <p>01/19/13: yelling "F...You."</p> <p>01/19/13: hitting, kicking, spitting and</p> | | | |

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| | <p>banging head on door.</p> <p>01/19/13: yelling "suck my d...."</p> <p>01/20/13: kicking staff, scratching his face, yelling "suck my d..." "rub my d...."</p> <p>01/20/13: kicked staff, scratched face, yelling "I want to suck your p..." "suck my d...you black b...."</p> <p>Of the 62 behaviors, 22 of the behaviors required PRTs.</p> <p>IDT (Interdisciplinary Team) notes dated 11/06/12 through 01/02/13 neglected to mention the behaviors and the behaviors which resulted in PRTs, and/or a plan on specifically how staff were to deal with the behaviors of client G to prevent reoccurrence.</p> <p>Client H's records were reviewed on 01/24/13 at 1:06 PM. Client H's record contained the following information related to client H's aggressive behavior:</p> <p>11/09/12: Client H admitted to facility. Transition Behavior Support Plan (TBSP) indicated client H's behaviors included, but were not limited to: physical aggression, self-harming behavior, verbal aggression, inappropriate sexual behaviors, elopement and stealing. Client</p> | | | | | | |

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| | <p>H's diagnoses included, but were not limited to: Moderate Mental Retardation, Impulse Control Disorder, Depressive Disorder and Psychotic Disorder.</p> <p>09/10/12: BSP (Behavior Support Plan) included psychiatric medications and restraint techniques for control of client H 's behaviors.</p> <p>Behavior Incident Reports indicated client H had 31 documented behaviors which included but were not limited to physical aggression to staff, kicking, hitting, spitting, profanity and/or self harm, from 11/16/12 to 01/02/13 which occurred on the following dates and all of which required PRTs:</p> <p>11/16/12: client to staff aggressive behavior - required PRT.</p> <p>11/16/12: aggressive behavior - required PRT.</p> <p>11/18/12: self harm, stabbed arm with pen - required PRT.</p> <p>11/18/12: banging head on fire extinguisher - required PRT.</p> <p>11/19/12: aggressive behavior required PRT.</p> <p>11/19/13: aggressive behavior required</p> | | | | | | |

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| | <p>PRT.</p> <p>11/21/12: hitting staff - required PRT.</p> <p>11/26/12: aggressive behavior required PRT.</p> <p>11/27/12: threw water at peer (unidentified) - required PRT.</p> <p>11/27/12: hitting, kicking at staff, tried to pull fire extinguisher off wall - required PRT.</p> <p>11/27/12: self harm - cut self with broken battery pack - required PRT.</p> <p>11/29/12: tried to bite staff - required PRT.</p> <p>11/30/12: bit self, threw chair, tried to bite staff - required PRT.</p> <p>12/03/12: hit staff in chest.</p> <p>12/10/12: hitting walls, hitting and kicking at staff - required PRT.</p> <p>12/10/12: bit self - required PRT.</p> <p>12/10/12: threw shoe at staff, digging and clawing at wound on leg - required PRT.</p> <p>12/18/12: hitting/kicking walls and fire door, bit self, required PRN medication - required PRT.</p> <p>12/23/12: kicking staff, bit, spit and kicked peer (client K), swearing, bit staff - required PRT.</p> <p>12/27/12: tossing tables/chairs, biting self, swearing, "get the f ... away" to staff</p> | | | | | | |

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| | <p>- required PRT.</p> <p>12/28/12: hit staff - required PRT.</p> <p>12/28/12: aggressive behavior required PRT.</p> <p>12/30/12: throwing chairs, knocking stuff off table, threatening to physically attack staff and peers, punching, kicking, biting staff - required PRT.</p> <p>12/30/12: throwing chairs - required PRT.</p> <p>12/30/12: bit self - banging head on door - required PRT.</p> <p>12/30/12: aggressive behavior required PRT.</p> <p>12/30/12: aggressive behavior required PRT.</p> <p>12/30/12: aggressive behavior required PRT.</p> <p>12/31/12: slamming doors, throwing chairs, kicking doors, trying to take fire extinguisher off wall, bit staff, scratched, hit, kicked staff, cussing threatening staff - required PRT.</p> <p>12/31/12: hitting staff - required PRT.</p> <p>01/02/13: pushing staff, tried to grab staff 's neck - required PRT.</p> <p>Of the 31 behaviors, 30 required PRTs.</p> <p>IDT (Interdisciplinary Team) notes dated</p> | | | | |

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| | <p>11/13/12 through 01/02/13 neglected to mention all of the behaviors or a plan on specifically how staff are to deal with the numerous occurring behaviors of client H to prevent reoccurrence.</p> <p>Client I's records were reviewed on 01/24/13 at 11:06 AM. Client I's record contained the following information: 08/20/12: Admitted to facility. 09/10/12: ISP (Individual Support Plan) indicated, "Sexuality Awareness: [Client I] requires supervision to remain safe in sexual situations. He has not demonstrated that he understands who can give consent and has difficulty discriminating between children and adults. Reports indicate his inability 'to control his sexual urges.' [Client I] has extensive history of sexually inappropriate behaviors, and has a current psychiatric diagnosis of Pedophilia. It was also noted he was previously arrested and charged with 2 counts of child molestation in October 2005."</p> <p>09/10/12: BSP (Behavior Support Plan) indicated client I's behaviors included, but were not limited to: manipulating</p> | | | | |

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| | <p>behavior, verbal aggression, physical aggression, hostility, inappropriate touching and sexual aggression. Client I's diagnoses included but were not limited to: Mild Mental Retardation, Pedophilia and Impulse Control Disorder. The BSP indicated, "Additionally, it was reported [client I] has stated on more than one occasion, he cannot distinguish between children and adults because although the faces of child (sic) younger, 'there is not much difference in their bodies' ...It was also reported he would continually touch the individual regardless of whether the person consented to his advances or not ...also noted he appeared to refuse the idea that others are not sexually attracted to him and is unable to control his state of arousal."</p> <p>01/2013: ISP Goal Documentation Sheet indicated, " [Client I] will increase his knowledge of rights and responsibilities associated with sexuality. The purpose of this program is to assist [client I] in improving his capacity for independent living by increasing his recognition of rights and responsibilities associated with appropriate sexual relationships. The</p> | | | | | | |

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| | <p>staff need to ask [client I] the following questions: 1) Do you have the right to not be touched if you don't wish to be?, 2) Name at least 3 forms of birth control (answers can include but are not limited to: condoms, birth control pills, abstinence, diaphragms), 3) What is the appropriate age of a consulting adult to be able to have sex?"</p> <p>01/14/13: Team Meeting Summary document indicated, "Reason For Meeting: Individuals have allegedly had sex in the bathroom. An investigation is taking place. Both parties consented."</p> <p>Client R's records were reviewed on 01/24/13 at 3:24 PM. Client R's record contained the following information related to client R's aggressive behavior: 09/20/12: Client R admitted to facility. Transition Behavior Support Plan (TBSP) indicated client R's behaviors included, but were not limited to: history of elopement, physical aggression, property destruction, verbal aggression/threats/intimidation, program refusal, inappropriate sexual behavior, self-harming injury and stealing. Client</p> | | | | |

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| | <p>R's diagnoses included, but were not limited to: Moderate Mental Retardation, Antisocial Personality Disorder, Impulse Control Disorder and Autistic Disorder.</p> <p>10/10/12: BSP (Behavior Support Plan) included psychiatric medications and restraint techniques for control of client R's behaviors.</p> <p>Behavior Incident Reports indicated client R had 6 documented behaviors from 11/09/12 to 01/05/13 on the following dates:</p> <p>11/09/12: client R aggressive to peer (unidentified), pulled peer from chair to floor - required PRT.</p> <p>11/09/12: flipped tables, hit staff - required PRT.</p> <p>11/17/12: aggressive behavior, fractured staff' s finger - required PRT.</p> <p>11/29/12: punched walls - hit staff - required PRT.</p> <p>12/16/13: threw chair - slapped peer (unidentified) - required PRT.</p> <p>01/05/13: hit peer (client G) who sat in his wheelchair - hit staff - required PRT.</p> <p>Of the 6 behaviors, 6 required PRTs and 1 of the 6 resulted in injury to staff which</p> | | | | | | |

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| | <p>required surgical repair.</p> <p>Client U's records were reviewed on 01/23/13 at 3:24 PM. Client U's record contained the following information related to client U ' s aggressive behavior: 10/25/12: Client U admitted to facility. Transition Behavior Support Plan (TBSP) indicated client U's behaviors included, but were not limited to: history of elopement, physical aggression, property destruction, verbal aggression/threatening and self-harming behavior. Client U's diagnoses included, but were not limited to: Moderate Mental Retardation, Pervasive Developmental Disorder, Intermittent Explosive Disorder and Bipolar Disorder.</p> <p>11/09/12: BSP (Behavior Support Plan) included psychiatric medications and restraint techniques for control of client U's behaviors.</p> <p>Behavior Incident Reports indicated client U had 1 documented behaviors causing significant injury to staff on 11/30/12. During a PRT staff #28's left little finger was dislocated and required medical</p> | | | | |

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| | <p>treatment.</p> <p>The "Employee's Work Injury/Illness Reports" from 11/06/12 through 01/13/13 were reviewed on 01/25/13 at 10:15 AM. The reports indicated there were 26 incidents of aggressive client behavior involving 11 clients and staff which resulted in the following:</p> <p>11/06/12: Client E threw game and hit staff #1 in the right hand. Staff #1 was blocking the item to prevent being struck in the head by the hard plastic item.</p> <p>11/09/12: Client R was having a behavior and attacking another client and staff #2 was hit in the nose.</p> <p>11/09/12: Client R was throwing items without provocation and hit staff #3 ' s nose.</p> <p>11/17/12: Client R was knocking over tables and threw a chair. Staff #10 attempted to block the chair and his thumb was "smashed against the table." Staff #10's left thumb was broken and required surgery to repair.</p> <p>11/19/12: Client Z was being placed in a PRT (Primary Restraint Technique) and began moving and kicked staff #4 in the face.</p> <p>11/19/12: Client Z was being placed in a second PRT and staff #4 was kicked and staff #4 fell backwards and "heard a pop near my left big toe."</p> | | | |
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| | <p>11/26/12: Client H was being placed in a PRT and bit staff #5's right arm.</p> <p>11/28/12: Client D was being placed in a PRT and pulled out a "small patch" of staff #6's hair.</p> <p>11/28/12: Client M threw a chair at another client and staff #7 got hit with the chair while trying to block it causing a bruise to her right arm.</p> <p>11/29/12: Client G was picking at his scabs and staff #8 was trying to "restrain him from self-harm, he scratched me." Staff #8 was scratched on his left wrist and hand.</p> <p>11/30/12: Client M was being placed in a PRT and staff #9 was assisting another staff member when client M grabbed staff #9's hair and shirt and threw her to the floor. Client M was attempting to break a window.</p> <p>11/30/12: Client U was hitting her head on the wall and staff #28 was attempting to place her in a PRT and was injured. Staff #28's left little finger was dislocated.</p> <p>12/09/12: Client D punched staff #10 in the right eye.</p> <p>12/17/12: Client A was "going after another client (client J)" when staff #21 tried to intervene, client J tried to hit client A with a chair and client A "grabbed my hair pulling my hair out and pushing me up against the wall, starching (sic) my arm up."</p> <p>12/17/12: Client A was being placed in a</p> | | | | | | |

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| | <p>PRT and grabbed staff #4's hair. Staff #4 wrote, "she yanked and pulled my hair without relenting. At some point during the altercation she scratched my face on the right side underneath and to the side of my right eye. My glasses were also damaged. A large handful of my hair was removed from my head."</p> <p>12/17/12: Client U's hands were attempting to be restrained when she scratched staff #22 on her right hand and fingers.</p> <p>12/18/12: Client H was being placed in a PRT when client H moved and staff #4 was, "thrown off [client H's] legs hitting right elbow onto the ground which bruised and caused a rug burn."</p> <p>12/19/12: Client R was being "aggressive" and "grabbed [staff #23's] "shirt and tried to bite her face." Staff #23 received injury to her head, right eye area and irritation on the back of the neck.</p> <p>12/31/12: Client H "bit me," staff #8 indicated when he was speaking with the client.</p> <p>01/02/13: Client U was attempting to bang her head and bit another staff. QSP #2 was bitten on her left thumb when she "went to grab her head."</p> <p>01/02/13: Client U was being placed in a PRT and staff #2 was assisting. Staff #2 slipped on the floor and client U kicked staff #2 in her left ribs causing pain.</p> <p>01/06/13: Client Z was, "placed in a PRT</p> | | | | | | |

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| | <p>and she was kicking me in the leg." Staff #24's leg was bruised from the kicks.</p> <p>01/06/13: Client Z was being placed in a PRT and "was fighting another staff, I intervened client (Z) scratched me."</p> <p>01/07/13: Client P was, "agitated and threw a chair, I put my left hand up to block the chair." Staff #26 was struck in the left hand by the chair resulting in pain to her fingers.</p> <p>01/07/13: Client P was being placed in a PRT and "head butted staff." Client P caused pain to staff #27's nose.</p> <p>01/13/13: Client Z threw a chair at staff #28. Staff #28 "tried to dodge the chair" resulting in pain and bruising to the left knee.</p> <p>The facility's reportable incident reports, BIRs and/or investigations indicated there were 129 incident of aggressive behaviors for clients B, D, E, G, H, I, M, R, U and Z from 11/01/12 to 01/22/13 (not all inclusive). The facility neglected to investigate, address and provide effective corrective action, to prevent client injuries as a result of client aggressive behavior, staff injuries as a result of client aggressive behavior, use of client restraints, address aggressive client behaviors, client to client aggression to track/ prevent patterns and trends of aggressive behavior, and neglected to provide an environment to address client</p> | | | |

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| | <p>behaviors to protect clients and prevent potential abuse of clients.</p> <p>An interview with Administrative Staff #3 (AS #3) was conducted on 01/23/13 at 10:34 AM. The AS #3 indicated the facility was inputting the BIRs into the data base. She indicated the facility will be reviewing for restraints more than 20 minutes and PRN medications used during restraints. She indicated this has not been done yet. She indicated the data base is capable of trending of incidents/accidents and grievances of staff and clients to look at patterns and the system will track more closely the QA (Quality Assurance) process. She indicated at the current time the patterns/trends for the aggressive behavior collectively in the environment had not been tracked.</p> <p>An interview with Administrative Staff Team (Administrative Staff #1, #3, #4, #5, Behavior Support Coordinator #1, Health Service Coordinator #1, Transitional Team Coordinator, #1 and #2, Director #1 and Qualified Support Professional #1 and #2) was conducted on 01/28/13 at 3:52 PM. The Administrative Team indicated prior to the clients' admissions they were aware of the fact that the clients admitted to the facility had a history of aggressive behaviors which</p> | | | | | | |

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| | <p>required psychiatric medication and physical restraints. They indicated staff and clients have been injured by the aggressive behaviors which continue to occur at the current time.</p> <p>The facility's policy and procedures were reviewed on 1/23/13 at 3:00 PM and at 5:12 PM. The facility's 8/12 revised policy entitled Reporting and Investigations indicated "It is the policy of Warner Transitional Services (WTS) to protect individuals who may be vulnerable to abuse, neglect or exploitation, mistreatment, or a violation of client rights. Employees, agents and volunteers must treat clients and other individuals with dignity and respect. The neglect, physical or verbal abuse of any client or another individual within or outside of Warner Transitional Services will not be tolerated...." The policy indicated "...If an allegation of abuse or neglect is made, the Qualified Support Professional (QSP) or Safety/Security Professional (SSP) will ensure the individual is moved to a safe location. The QSP or SSP will notify all appropriate WTS staff including the Executive Director/Administrator who is responsible for ensuring that all investigations are completed thoroughly and that records of the investigation are</p> | | | | |

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| | <p>maintained...." The facility's June 2012 policy entitled Employee Conduct indicated "Each person receiving services from WTS will receive humane care and protection from harm...." The policy indicated clients had the right to be free from neglect and/or abuse.</p> <p>This federal tag relates to complaints #IN00121785 and #IN00122955.</p> | | | |

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| W000153 | <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on 1 of 7 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to provide evidence an allegation of staff to client abuse was immediately reported to the administrator for client E.</p> <p>Findings include:</p> <p>Client E's record was reviewed on 1/23/13 at 1:24 PM. Client E's 12/6/12 Clinical Therapy Note indicated unit staff had the therapist to speak with client E in regard to her weight. The note indicated when the therapist came to the unit to speak with client E, "...She (client E) asked 'You won't hurt me will you?' She said a '[staff #14]' staff had touched her and squeezed her breast. She stated staff knew about this & (and) writer followed up (with) TTC (Treatment Team Coordinator) [TTC #1] & she stated it had been investigated...."</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 1/23/13 at 10:29 AM. The facility's</p> | W000153 | <p>The administration will ensure facility staff report all allegations of abuse / neglect and injuries of unknown source immediately to the Administrator. This will be accomplished for all clients:</p> <ul style="list-style-type: none"> - Reporting format changed to specifically note that the Administrator was notified immediately of all allegations of abuse / neglect and injuries of unknown source, providing name of person notifying Administrator, date, and time. · Reporting format completed by: 1/26/13. · Supervisors trained on specifics requiring immediate Administrator notification: 2-6-13 · Responsible Parties to assure implementation / follow through: Treatment Team Coordinators | 02/06/2013 | | | |

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| | <p>reportable incident reports and/or investigations from 11/1/13 to 1/23/13 did not indicate the facility reported the allegation of staff to client sexual abuse to the administrator.</p> <p>Interview with TTC #1 on 1/28/13 at 12:10 PM indicated she was aware of the allegation of abuse. TTC #1 indicated she could not remember when the incident occurred but, client E was mentioning an incident/allegation which had been looked at prior to 12/6/12. TTC #1 indicated the allegation of staff to client abuse had been reported to the administrator. TTC #1 did not provide evidence and/or documentation the 12/6/12 allegation of abuse had been reported to the administrator.</p> | | | | | | |

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| W000154 | <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on observation, interview and record review for 9 of 10 sampled clients (A, B, C, D, G, H, E, F and I) and for 4 additional clients (R, U, M and Z), the facility failed to conduct thorough investigations in regard to allegations of abuse, neglect and/or injuries of unknown source, and/or failed to provide evidence all allegations of abuse/neglect and/or injuries of unknown source were investigated.</p> <p>Findings include:</p> <p>1. The facility's reportable incidents, Behavior Incident Reports (BIRS) and/or investigations were reviewed on 1/23/13 at 10:29 AM. The reportable incident reports indicated the following:</p> <p>-11/9/12 "[Client C] was in her room and sent another client with a note for staff. [Client C] had written that she would be dead by morning. When staff went to her room to speak with [client C] they found a bra tied around her neck. She allowed staff to help her remove the bra. [Client C] told staff that her peer's constant behaviors were just too much, that this peer took all of staff's attention. [Client</p> | W000154 | <p>Facility has developed and will maintain a reproducible system of completed investigations (within 5 working days to provide evidence of thorough investigations regarding allegations of abuse (includes client to client aggression), neglect and/or injuries of unknown source for clients.</p> <ul style="list-style-type: none"> · "Administrators Notification and Investigation Protocol" (attachment #4) was implemented on 2/6/13 · Supervisory staff (QSPs) trained on protocol by Treatment Team Coordinators by 2/15/13; · Investigators identified and trained by QA Director: 2/15/13 · "Reporting and Investigations Policy" updated by QA Director on 2/15/13 with appropriate staff trained. (attached #5) · Responsible Parties: <ul style="list-style-type: none"> o Treatment Team Coordinators to assure proper | 03/07/2013 | | | |

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| | <p>C] said that she had swallowed pieces of her broken CD and pushed a pencil up into her private area and was referring to this rather than a needle. [Client C] was seen by the nurse and evaluated. The Doctor gave orders for her to be seen in the emergency room. She was also placed on Level 1 Suicide Precautions (arm length reach of staff at all times). The report from the ER (emergency room) found no evidence that she had swallowed any non-edible objects and could only state there may be a particle under the skin of her arm but they could not remove it but to follow-up orthopedist or surgeon if they felt it is necessary...."</p> <p>A 11/22/12 follow-up report indicated client C "...had scratches on both wrists as well as a cut on her left wrist. It was not confirmed what the exact item was that [client C] had inserted into her vagina; however evidence suggests that she did in fact have a foreign object placed in there at some point. She used the restroom immediately prior to leaving the facility to go to the hospital and staff reported seeing blood on the toilet paper after she wiped. The nurse assessed [client C] for injury and reported she did have abrasions in her genital area; however the injuries were not significant enough to warrant medical attention beyond first aid care.... [Client C] had an x-ray performed at the</p> | | <p>reporting;</p> <ul style="list-style-type: none"> o Investigators / QA Director to assure all allegations of abuse/neglect and/or injuries of unknown source are investigated within 5 working days with recommendations/corrective action. · All investigation protocols to be fully implemented by: 3/7/13 | |

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| | <p>Emergency Room...The hospital reported that [client C] had a foreign object lodged beneath her skin in the left ulna/radius. The image shows that the particle is approximately 1/2 inch in length. The recommendations of the hospital were to see if the particle would surface on its own through the healing process but to seek surgical consult if it does not appear...." The follow-up report and/or 11/9/12 reportable incident report failed to indicate any additional investigation in regard to neglect involving staff supervision and/or monitoring.</p> <p>-12/18/12 "At approximately 10:14pm on 12/18/2012, [client C] was in her bedroom. Her roommate walked into the room and noticed that [client C's] hands and head were underneath the covers. She (roommate) asked her (client C) to take her hands out so that she could see them and [client C] refused. Her roommate then went to alert staff that she thought [client C] was 'up to something.' Staff immediately went into [client C's] room. When they entered, head was peeking out of the covers (sic). Staff asked her to remove her hands from under the covers. She complied. She showed her right arm which had a cut/scrape on the right wrist. She stated that she had pieces of broken plastic from her DVD player that she had inserted in there. She</p> | | | | |

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| | <p>also said that she had swallowed some pieces of the same material. When staff had her take off the covers completely, they noticed she had abrasions to her neck where she had tied a cord to the DVD player around herself. Staff asked [client C] why she was trying to hurt herself. [Client C] smiled and said she knew what she 'had to do to get out of here.'...[Client C's] QSP (Qualified Support Professional) took [client C] to the Emergency Room to have her wrist and abdomen X-rayed since [client C] stated that she had ingested and inserted glass into her arm. X-ray results revealed that [client C] has a foreign object in her right wrist and recommended that she follow up with a hand surgery specialist for removal of the item...Immediate: WTS will continue to keep [client C] in staff sight at all times per her precaution and will follow the behavioral support interventions as outlined in her behavior support plan...."</p> <p>The facility's 12/27/12 follow-up report indicated client C was placed on Level 1 Suicide Precautions after the 12/18/12 incident occurred. The follow-up report indicated "...[Client C] had been taken off all of her precautions prior to this incident taking place; therefore she was not on any program requiring her to be in staff sight at all times. She was under the care and</p> | | | | | | |

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| | <p>supervision of staff with 15 minute checks when not in the milieu of the dayroom. Therefore, it is not appropriate to deem this an incident of neglect because staff were implementing appropriate supervision within the guidelines of her psychiatrist. Unfortunately, this situation has proven that this is not an appropriate type of supervision for her at this time and therefore WTS will continue to follow the precaution recommendations of [name of psychiatrist] as well as put other measures in place (removal of personal belongings from room) to provide a safe environment for [client C]...." The facility's 12/18/12 reportable incident report and/or 12/27/12 follow-up report did not indicate if the facility had conducted an investigation for possible neglect to determine if the facility actually conducted 15 minute checks on client C on 12/27/12, and/or how the checks were conducted due to the amount of injuries client C caused to herself.</p> <p>Interview with Treatment Team Coordinator (TTC) #1 on 1/28/13 at 12:10 PM indicated the facility did not conduct/document an investigation in regard to allegations of possible neglect in regard to staff monitoring for the 11/9/12 and 12/18/12 self harm incidents.</p> | | | |

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| | <p>2. The facility's reportable incident reports, BIRS and/or investigations were reviewed on 1/23/13 at 10:29 AM. The facility's 1/13/13 reportable incident report indicated "On 1-13-2013, it was reported to staff by [client A], individual, that she had sex with her boyfriend, [client I], while in the bathroom of the Canteen room. An internal investigation has occurred in which video footage was reviewed and statements were gathered. [Administrative staff #1], Executive Director and [administrative staff #2], Interim Director of Operations discussed the incident with [name of Bureau of Developmental Disability Services (BDDS) staff] on 1-16-13 as there were questions as to whether or not this was a reportable incident. Both individuals consented and neither of them has a guardian. [Name of BDDS staff] asked that we report the incident and [name of Adult Protections (APS) staff] from APS were also notified verbally. Investigation results were unable to substantiate if sexual intercourse has actually taken place due to a lack of video access to the bathroom. Staff [staff #11], who was monitoring the individuals during their visitation, was suspended and consequently terminated on 1-18 due to poor judgement of allowing these two individuals to spend time together in the restroom, although both were consenting</p> | | | |

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| | <p>adults and both requested to go into the restroom together."</p> <p>The facility's 1/14 and 1/15/13 Internal Investigation Report indicated "On 1-13-13, [client A and client I] (currently a couple) were in the Canteen room for an evening visit. Staff, [staff #11], was supervising the visit. Upon returning from the visit, [client A] stated to staff [staff #12] that she had sex that evening with her boyfriend, [client I] while in the Canteen room bathroom... I asked her where the staff was at, she told me that he (staff #11) was sitting in the chair and that he them permission to go into the bathroom (sic). I explained to [client A] that she should have taken the sex Ed. (education) Classes that I have been talking to her about. She said okay and then she wanted to speak to the nurse about some things. On 1-14-2013, [client I] stated that he asked his staff on the evening of 1-13-2013 if he could go in the bathroom to have sex together (with his girlfriend). He also stated that he did have sex with his girlfriend in the bathroom and that both she and he consented to this act. [Client I] also stated that he did not use protection and has had sexual education training at [name of hospital] 5 weeks prior to admission at Warner Transitional Services. On 1-14-2013, [client A] gave</p> | | | |

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| | <p>the following statement 'On the evening of January 13, 2013 at approximately 9:00pm, I went to the canteen within my boyfriend, [client I], and his new staff. We were sitting in the canteen talking and listening to music. We were whispering to each other. I told [client I] that WTS is taking too long for the sex education classes. He told me that he can ask his new staff that just got out of orientation if we can go into the bathroom for the last 5 minutes of our personal visitation. We talked back and forth with each other for about 5 minutes trying to figure out who should be the one to ask the staff. Finally I spoke up. I asked him [the staff] if we could go in the bathroom alone for 5 minutes. The staff asked us if we were our own guardians. We said yes. Then he asked us if it was in our programs. We said yes; but we were lying. The staff then saluted and said 'Go ahead. Let me know when you are done.' We had sex while we were in the bathroom...." The facility's investigation indicated the client did not use any protection and they both indicated they had sexual intercourse. The facility's 1/14 and 1/15/13 investigation indicated "...Upon returning back to the unit, I (client A) noticed that I had vaginal bleeding. The nurse was notified and examined my private area. She also provided me with information on sexually transmitted diseases. Also on</p> | | | | | | |

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| | <p>1-14-12013, when asked, [client A] stated that she has had sexual education training three times prior to coming to Warner Transitional Services...." The facility's investigation indicated staff #11 admitted to allowing the clients to go into the bathroom for private time together. Client #11's 1/13/13 witness statement indicated staff #11 was to "monitor" clients A and I in the canteen area. Staff #11's witness statement indicated clients A and I were in the bathroom for 10 to 15 minutes. The facility's investigation indicated the facility's videotape indicated the clients were in the bathroom alone for 18 minutes and "...All clients should be supervised at least every 15 minutes..." The facility's "...Conclusion: [Clients I and A] both entered the Canteen bathroom together. Due to the fact that there is no video access in the bathroom, it could not be concretely substantiated that the two individuals had intercourse. [Staff #11], staff, exercised poor judgement in allowing this action to take place due to a lack of knowledge of the appropriate way to handle this situation that arose. Staff [staff #11] did not seek information from the correct source as he sought information from the clients themselves as opposed to referring to their support plans or his supervisor. Actions(s) Taken: Staff, [staff #11], who was monitoring the individuals during</p> | | | | | | |

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| | <p>their visitation, was suspended and recommendation is termination due to poor judgement leading to poor supervision."</p> <p>Client I's 1/14/13 WTS Behavioral Report Continuation Form (witness statement) indicated client I had an "orgasm" inside client A. The witness statement indicated "What did she say afterwards?" She asked me (client I) to get up off of her." The 1/14/13 witness statement indicated he consented to having sex with client A and was worried he (client I) would get in trouble for what he did.</p> <p>Client A's 1/14/13 typed witness statement indicated client I did not use a condom when they had sex.</p> <p>The facility's recorded/audio tape was reviewed on 1/23/13 at 3:35 PM. The video/audio tape was of clients A and I and staff #11 in the Canteen room of the facility at 9:46 PM on 1/13/13. The video/audio tape indicated music was playing in the canteen which prevented clients A and I's conversation from being heard. The video tape did indicate the clients were sitting in one area of the canteen and staff #11 was on the other side of the room looking at a magazine. Clients A and I could be seen talking/whispering to each other and</p> | | | | |

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| | <p>looking over to staff. At 9:52 PM, the video indicated the clients cut the music off. The video indicated client A asked staff if they could spend the last 5 minutes of their visitation in the bathroom of the Canteen. The video/audio tape showed staff #11 asked clients A and I if this was in their program. The video/audio tape indicated both clients stated "Yes." Staff #11 saluted clients A and I and both clients walked into the Canteen bathroom and closed the bathroom door. Staff #11 sat in the Canteen room whistling, stood whistling and walked out of sight of the camera at 9:57 AM at the door/entrance of the Canteen Room. Staff #11 could still be heard whistling even the staff could not be seen. Staff #11 then stated to the clients in the bathroom, "It is a little after 10." Client A responded "Ok." Client A could be heard moaning/making sounds, in the Canteen bathroom, with the door closed. At 10:04 PM, staff #11 stated "You got to wrap it up. Wrap it up." Client A again could be heard moaning and making sounds in the Canteen bathroom. At 10:07 PM, staff #1 stated "We got to roll. We got to roll." At 10:09 PM, Clients A and I came out of the bathroom dressed with client A trying to straighten out her hair with her hand. Clients A and I retrieved their items from the table and began to walk out of the Canteen room.</p> | | | | | | |

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| | <p>The facility's 1/14 and 1/15/13 investigation indicated the facility failed to conduct a thorough investigation in regard to the above incident. The facility failed to substantiate clients A and I had sexual intercourse in the bathroom even though both clients indicated they had sexual intercourse, and by hearing moaning/sounds from the bathroom of the facility's video and audio surveillance. The facility's investigation failed to interview any medical staff/nurse in regard to the client's vaginal bleeding, and failed to interview any additional staff and/or clients at the facility to determine if this type of incident/practice had occurred before with any other clients and/or staff. The facility's investigation failed to include any recommendations and/or corrective actions to prevent similar incidents in the future.</p> <p>Interview with client A on 1/22/13 at 4:00 PM indicated client A and client I had sex on the bathroom floor in the Canteen room. Client A indicated they asked facility staff for permission to have private time in the bathroom. Client A stated the staff said "Yes." Client A stated the facility staff "saluted them."</p> <p>Interview with TTC #1 and #2 on 1/23/13 at 3:00 PM indicated sounds could be</p> | | | | | | |

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| | <p>heard coming from the bathroom during the 1/13/13 incident upon review of the audio tape. TTC #1 indicated the facility could not substantiate clients A and I had sexual intercourse as it could not be seen what happened in the bathroom.</p> <p>Interview with HSC #1, QSP #2 and TTC #1 on 1/28/13 at 12:10 PM, indicated clients A and I were boyfriend and girlfriend. TTC #1 and QSP #1 indicated facility staff allowed clients A and I to go into the bathroom together. TTC #1 indicated the facility did not substantiate intercourse had taken place with clients A and I as there were no cameras in the bathroom. HSC #1 indicated she was not sure if a nurse assessed client A after the allegation was made. HSC #1 indicated she was not aware of the vaginal bleeding as she was not at the facility at that time. HSC #1 indicated if there was an assessment, nursing staff should have documented the assessment. TTC #1 and QSP #2 indicated clients A and I had not been allowed to have sex in the past.</p> <p>Interview with administrative staff #1 on 1/28/13 at 3:59 PM indicated no additional interviews were conducted in regard to the investigation. Administrative staff #1 indicated it could not be substantiated clients A and I had sexual intercourse as there was no camera</p> | | | | | | |

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| | <p>in the bathroom.</p> <p>3. The facility's reportable incident reports and/or investigations were reviewed on 1/23/13 at 10:29 AM. The facility's 1/8/13 reportable incident report indicated client F had an appointment at a government office where the client was in a good mood. The 1/8/13 reportable incident report indicated "...While on the ride home, at approximately 2:20 pm, [client F] had made up an elaborate, detailed story of her social history stating that she was adopted and that her late maternal grandmother was her 'real' mother...When we were about 10 minutes away from returning to the WTS facility, the QSP looked over and saw that [client F's] entire affect had changed. She was visibly agitated for an unknown reason. QSP asked [client F] if she was okay, and [client F] responded with vulgar profanity and said she did not want to talk to her QSP. QSP replied that's okay and that we're almost back so she can have some private time when we get there to help relieve some of her anxiety. When the vehicle was about 5 minutes away from the facility, [client F] took her family photos out of her purse and started ripping her photo into many little pieces. Then she took a CD case and started to break the case. QSP removed the CD case from [client F] for fear that [client F] was going</p> | | | | | | |

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| | <p>to harm herself with it. Immediately [client F] became physically aggressive towards her QSP (who was driving) and was continuously throwing punches to the QSP's face and right arm. QSP was able to block most of the hits with her right arm and pushed [client F] off of her. QSP informed [client F] that she was driving and that it was not safe for either one of them. In turn, [client F] tried to pull the shifter out of gear while the vehicle was in motion. Once again, QSP reminded [client F] that it was not safe to do that and that they were almost back to the facility. While they were on [name of busy street], less than a mile from WTS, [client F] reached over and pulled the entire steering wheel towards the passenger side which caused the vehicle to swerve into the other lane of traffic. There were no cars in that lane at that time. QSP attempted to call WTS for assistance to come outside to help when they arrived, but [client F] began hitting the QSP again and then opened the passenger side door. She leaned out of the door, however she had her seatbelt on as a restraint. QSP had grabbed on to her jacket and pulled her back into the vehicle. She tried to take off her seatbelt, but QSP held it in the socket with the right hand and continued to steer the vehicle with the left hand. [Client F] had climbed out of her seatbelt. QSP made</p> | | | |
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| | <p>the call at that point to bring the vehicle to a stop since [client F] was no longer secured in the car. [Client F] opened the door and jumped out of the vehicle while it was still in motion. The QSP got out of the car and yelled for [client F] who was running down the middle of [name of busy street] towards oncoming traffic. At 2:28 pm, the QSP had WTS on the phone at this time to send out emergency assistance to help retrieve [client F]. Two DSPs (Direct Support Professionals) and a LDSP (Lead Direct Support Professional) joined the QSP within 2 minutes and they drove south on [name of busy street] towards the direction [client F] had eloped. A car on the opposite side of the road had flagged down the vehicle. An off-duty staff that works on the hall with [client F] was coincidentally driving down the same street with her mother on the way to the grocery store when she had seen [client F] running. She pulled over and [client F] voluntarily got in her car. QSP and other staff pulled up to the vehicle. [Client F] was sitting in the backseat crying. (She had also broken her glasses while she was running.) Later in the evening, [client F] was describing the events of the day to a Safety and Security Professional and [client F] kept referring to the incident as 'Happy feet'...Immediate: There is an emergency IDT meeting scheduled for [client F] on</p> | | | |

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| | <p>Thursday January 10, 2013 to discuss this event and make revisions as deemed necessary to her Behavior Support Plan. [Client F's] guardians will be participating via phone conference. Long-Term: WTS administration will meet to discuss possible revisions to the agency policy regarding client transports." The facility's 1/8/13 reportable incident report indicated the facility failed to conduct and/or provide evidence of an investigation for possible neglect in regard to staff monitoring/supervision, and/or indicate how client F broke her glasses during the 1/8/13 elopement incident.</p> <p>Client F's record was reviewed on 1/25/13 at 1:45 PM. Client F's 11/26/12 Transitional Behavioral Support Plan (TBSP) indicated client F was admitted to the facility on 11/26/12. The 11/26/12 TBSP indicated client F demonstrated the targeted behavior of elopement which was defined as "...Leaving designated area or staff supervision without permission. Previous placement reports that [client F] enjoys going to the doctor and will often NOT elope during doctor appointment outings, but must be closely supervised on all other outings. [Client F] has a history of attempting to manipulate staff to create an opportunity to elope. Last incident of attempted elopement was in March 2012...."</p> | | | | | | |

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| | <p>Client F's 1/2/13 Behavior Support Plan (BSP) Level 1 "Proactive or Preventative Strategies" section indicated "...5. Due to [client F's] history of elopement, impulsiveness, and self-harming behaviors, supervision requirements necessary for her to participate in community activities and off-ground activities include she is to be within line of sight and arm's reach of staff at all times. To reduce elopement while on community outings, [client F] will be transported by one staff who is designated as the driver and another staff who will monitor [client F]. [Client F] will sit in the back seat of the vehicle and will not sit behind the driver of the vehicle. Last documented incident of elopement was in March 2012...."</p> <p>Interview with QSP #2, TTC #1 and BSC #1 on 1/28/13 at 12:10 PM indicated client F had a history of elopement. QSP #2 indicated she was with client F on 1/8/13 when the incident occurred. QSP #2 indicated she was the only staff in the van with client F. QSP #2 indicated client F did fine until they were returning from the facility from her appointment in the community. QSP #2 stated "Within 30 seconds demeanor and affect changed. Can't say what triggered her." QSP #2 stated client F turned the volume up in the</p> | | | | | | |

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| | <p>van, ripped her pictures she had in her purse, hit QSP #2, "busted" a CD case and hit QSP #2 with a purse. QSP #2 stated she did not stop and/or pull over as she knew client F was "an elopement risk." QSP #2 stated client F "turned wheel (steering) into traffic" and opened the vehicle door. QSP #2 indicated client F eloped from the vehicle and ran down the street where an off duty staff saw/found the client. QSP #2 stated at the IDT meeting, "She (client F) had no awareness or concern at meeting" in regard to what she had done on 1/8/13. When asked how client F's restrictions came about, QSP #2 stated client F's "Getting out of vehicle to do that was a safety risk of going out into traffic." TTC #1 and QSP #2 indicated staff #13 found client F on 1/18/13 after the client eloped from the vehicle as staff #13 was driving with staff #13's mother to go to the store. TTC #1 indicated no investigation had been conducted/documentated in regard to the 1/8/13 incident. When asked how client F broke her glasses, QSP #2 stated "She threw them." QSP #2 indicated client F broke her glasses after she eloped from the van.</p> <p>4. Client E's record was reviewed on 1/23/13 at 1:24 PM. Client E's 12/6/12 Clinical Therapy Note indicated unit staff had the therapist to speak with client E in</p> | | | | |

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| | <p>regard to her weight. The note indicated when the therapist came to the unit to speak with client E, "...She (client E) asked 'You won't hurt me will you?' She said a '[staff #14]' staff had touched her and squeezed her breast. She stated staff knew about this & (and) writer followed up (with) TTC (Treatment Team Coordinator) [TTC #1] & she stated it had been investigated...."</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 1/23/13 at 10:29 AM. The facility's reportable incident reports and/or investigations from 11/1/12 to 1/23/13 did not indicate the facility investigated the 12/6/12 allegation of abuse.</p> <p>Interview with TTC #1 on 1/28/13 at 12:10 PM indicated she was aware of the allegation of abuse. TTC #1 indicated she could not remember when the incident occurred but, client E was mentioning an incident/allegation which had been looked at prior to 12/6/12. TTC #1 indicated the allegation of staff to client abuse had been investigated. TTC #1 did not provide evidence and/or documentation the 12/6/12 allegation of abuse had been investigated.</p> <p>5. The facility's BDDS Reports were reviewed on 01/24/13 at 12:08 PM and</p> | | | | | | |

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| | <p>included the following incidents:</p> <p>Client B: 5 BDDS reports of client B to client (unidentified) aggression requiring PRTs on 11/26/12, 12/22/12, 01/17/13 and 01/22/13. There were no investigations available for review of these incidents.</p> <p>Client D: 2 BDDS reports of client D to client (unidentified) aggression requiring PRTs on 11/16/12 and 12/09/12. There were no investigations available for review of these incidents.</p> <p>Client G: 1 BDDS report of client G to client (unidentified) aggression on 01/19/13. There was no investigation available for review of this incident.</p> <p>Client H: 7 BDDS reports of aggressive behaviors requiring physical restraints on: 11/16/12, 11/21/12, 11/26/12, 11/29/12, 11/28/12, 11/30/12 and 12/31/12. There were no investigations available for review of these incidents.</p> <p>Client H: 2 BDDS reports of client G to client (unidentified) aggression on 11/27/12 and 12/23/12 (client K). There were no investigations available for review of these incidents.</p> <p>Client R: 1 BDDS report of aggressive</p> | | | | | | |

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| | <p>behaviors requiring physical restraints on: 11/17/12. The aggressive behavior resulted in injury to staff #10's left thumb which was broken and surgery was required to repair. There was no investigation available for review of this incident.</p> <p>Client R: 2 BDDS reports of client R to client (unidentified) aggression on 12/16/12 and 01/05/13 (client G). There were no investigations available for review of these incidents.</p> <p>Client U: 1 BDDS report of aggressive behaviors requiring physical restraints on: 11/30/12. The aggressive behavior resulted in injury to staff #28's left little finger which was dislocated and medical treatment was required to realign the finger. There was no investigation available for review of this incident.</p> <p>The "Employee's Work Injury/Illness Reports" from 11/06/12 through 01/13/13 were reviewed on 01/25/13 at 10:15 AM. The reports indicated the following incidents, involving clients and staff, which were not investigated: 11/17/12: Client R was knocking over tables and threw a chair. Staff #10 attempted to block the chair and his thumb was "smashed against the table." Staff #10's left thumb was broken and</p> | | | | |

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| | <p>required surgery to repair. There was no investigation available for review of this incident.</p> <p>11/30/12: Client U was hitting her head on the wall and staff #28 was attempting to place her in a PRT and was injured. Staff #28's left little finger was dislocated. There was no investigation available for review of this incident.</p> <p>12/17/12: Client A was "going after another client (client J)" when staff #21 tried to intervene, client J tried to hit client A with a chair and client A "grabbed my hair pulling my hair out and pushing me up against the wall, starching (sic) my arm up." There was no investigation available for review of this incident.</p> <p>12/17/12: Client A was being placed in a PRT and grabbed staff #4's hair. Staff #4 wrote, "she yanked and pulled my hair without relenting. At some point during the altercation she scratched my face on the right side underneath and to the side of my right eye. My glasses were also damaged. A large handful of my hair was removed from my head." There was no investigation available for review of this incident.</p> <p>An interview with the Transitional Team</p> | | | | |

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| | <p>Coordinator (TTC) #1 was conducted on 01/22/13 at 3:52 PM and on 01/24/13 at 3:10 PM. She indicated the investigations the facility had conducted were all given to us and there were no further investigations to provide. She further indicated the facility had recently started conducting more investigations after a recent survey in the first part of January and they were still putting things into place.</p> <p>This federal tag relates to complaint #IN00122955.</p> | | | | |

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| W000157 | <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview for 6 of 10 sampled clients (A, B, D, E, G and H) and for 5 additional clients (M, P, R, U and Z), the facility failed to initiate and document effective corrective action to prevent further incidents of client to client aggressive behavior, client to staff aggressive behavior and provide an environment to address and decrease the number of aggressive incidents involving clients.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) Reports were reviewed on 01/24/13 at 12:08 PM and included the following incidents:</p> <p>Client B: 5 BDDS reports of aggressive behaviors requiring physical restraints on: 11/26/12, 11/27/12, 12/03/12, 12/26/12 and 01/02/13. No record of documented effective corrective action was available for review for these incidents.</p> <p>Client B: 5 BDDS reports of client B to client (unidentified) aggression requiring PRTs (Primary Restraint techniques) on</p> | W000157 | <p>- the facility will initiate and document effective corrective action to prevent further incidents of client to client aggressive behavior, client to staff aggressive behavior and provide an environment to address and decrease the number of aggressive incidents involving clients.</p> <p>Ø Clients have been moved to single bedrooms, as of late January, 2013;</p> <p>Ø Facility staff have received retraining on the Handle With Care® Primary Restraint Technique (PRT), specifically with respect to the proper timing of use of physical restraint <u>focusing on verbal deescalation of behaviors</u> to resolve need for use of a physical restraint;</p> <p>National trainer (New</p> | 03/07/2013 | | | |

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| | <p>11/26/12, 12/22/12, 01/17/13 and 01/22/13. No record of documented effective corrective action was available for review for these incidents.</p> <p>Client B: Client B's 11/27/12, 12/10/12, 12/21/12, 01/09/13 and 01/12/13 Behavior Incident Reports (BIRs) indicated client B required PRTs. No record of documented effective corrective action was available for review for these incidents.</p> <p>Client D: 2 BDDS reports of client D to client (unidentified) aggression requiring PRTs on 11/16/12 and 12/09/12. No record of documented effective corrective action was available for review for these incidents.</p> <p>Client D: The BIRs where client D required PRTs on 12/09/12, 12/10/12, 01/09/13 and 01/09/13 (2nd episode), indicated no documented effective corrective action was available for review for these incidents.</p> <p>Client G: 13 BDDS reports of self harm on: 11/10/12, 11/16/12, 11/18/12, 11/27/12, 12/12/12, 12/17/12, 12/17/12 (second incident), 12/21/12, 12/30/12, 01/01/13, 01/05/13, 01/18/13 and 01/19/13. No record of documented effective corrective action was available</p> | | <p>York) from Handle With Care® will complete annual “train the trainer” on 2/4 – 2/7/13 with focus being given to de-escalation techniques, proper physical restraint techniques and prevention of injury / use of modified techniques.</p> <p>Responsible Party: Human Resources Coordinator</p> <p>Responsible Parties: Treatment Team Coordinators by 2/1/13.</p> <p>(Additionally)</p> <p>Behavioral Services Coordinator is reevaluating alternative methods to avert client aggression by individually assessing client BSPs and implementing changes as alternative resources to be utilized for clients to avert aggressive/ destructive behaviors.</p> | | | | |

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| | <p>for review for these incidents.</p> <p>Client G: 1 BDDS report of client G to client (unidentified) aggression on 01/19/13. No record of documented effective corrective action was available for review for this incident.</p> <p>Client G: The BIRs for the 9 aggressive behaviors required the use of PRTs on 11/16/12, 11/18/12, 11/22/12, 11/24/12 (2nd episode), 12/12/12, 12/16/12, 12/17/12, 12/22/12 and 01/18/13. The BIRs and/or record indicated no documented effective corrective action was available for review.</p> <p>Client H: 7 BDDS reports of aggressive behaviors requiring physical restraints on: 11/16/12, 11/21/12, 11/26/12, 11/29/12, 11/28/12, 11/30/12 and 12/31/12. No record of documented effective corrective action was available for review for these incidents.</p> <p>Client H: 2 BDDS reports of client G to client (unidentified) aggression on 11/27/12 and 12/23/12 (client K). No record of documented effective corrective action was available for review for these incidents.</p> <p>Client H: The BIRS for the 13 aggressive behaviors required the use of PRTs on</p> | | <p>Clients to be reassessed with addendums to BSPs with approval per HRC and legal guardian/HCR or other court appointed advocate as required by: 3/7/13 for identified clients / ongoing as individual client needs present;</p> <p>o Within the final investigation report submitted to administrator the investigators will document corrective actions to be taken that will be reviewed by the IDT for proper consideration and implementation;</p> <p>Quality Assurance Director will train investigators on ascertaining with proper IDT input the documentation of</p> | | |

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| | <p>11/16/12, 11/19/12, 11/19/12 (2nd episode), 11/27/12, 11/30/12, 12/10/12, 12/10/12 (2nd episode), 12/10/12 (3rd episode), 12/27/12, 12/28/12, 12/30/12, 12/31/12 and 01/02/13. The BIRS and/or record indicated no documented effective corrective action was available for review.</p> <p>Client R: 1 BDDS report of aggressive behaviors requiring physical restraints on: 11/17/12. The aggressive behavior resulted in injury to staff #10's left thumb which was broken and surgery was required to repair. No record of documented effective corrective action was available for review for this incident.</p> <p>Client R: 2 BDDS reports of client R to client (unidentified) aggression on 12/16/12 and 01/05/13 (client G). No record of documented effective corrective action was available for review for these incidents.</p> <p>Client R: 6 BDDS reports of aggressive behaviors requiring physical restraints on: 11/09/12, 11/09/12 (2nd episode), 11/17/12, 11/29/12, 12/06/12 and 01/05/13. No record of documented effective corrective action was available for review for these incidents.</p> <p>Client U: 1 BDDS report of aggressive behaviors requiring physical restraints on:</p> | | <p>corrective actions within the investigations;</p> <ul style="list-style-type: none"> · Treatment Team Coordinators with investigators input will assure appropriate corrective actions are in place and will address with IDT supervisors accordingly; · Quality Assurance Director will initiate a system to review trends in client aggressive behavior with data to be reviewed by respective IDTs; · Date to be completed / fully implemented: 3-7-13 | | |

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| | <p>11/30/12. The aggressive behavior resulted in injury to staff #28's left little finger which was dislocated and medical treatment was required to realign the finger. No record of documented effective corrective action was available for review for this incident.</p> <p>The "Employee's Work Injury/Illness Reports" from 11/06/12 through 01/13/13 were reviewed on 01/25/13 at 10:15 AM. The reports indicated there were 26 incidents of aggressive client behavior involving 11 clients and staff which resulted in no documented effective corrective action as exemplified by (not all inclusive):</p> <p>11/09/12: Client R was having a behavior and attacking another client and staff #2 was hit in the nose.</p> <p>11/09/12: Client R was throwing items without provocation and hit staff #3's nose.</p> <p>11/17/12: Client R was knocking over tables and threw a chair. Staff #10 attempted to block the chair and his thumb was "smashed against the table." Staff #10's left thumb was broken and required surgery to repair.</p> <p>11/19/12: Client Z was being placed in a PRT (Primary Restraint Technique) and</p> | | | | | | |

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| | <p>began moving and kicked staff #4 in the face.</p> <p>11/19/12: Client Z was being placed in a second PRT and staff #4 was kicked and staff #4 fell backwards and "heard a pop near my left big toe."</p> <p>11/26/12: Client H was being placed in a PRT and bit staff #5's right arm.</p> <p>11/28/12: Client D was being placed in a PRT and pulled out a "small patch" of staff #6's hair.</p> <p>11/30/12: Client M was being placed in a PRT and staff #9 was assisting another staff member when client M grabbed staff #9's hair and shirt and threw her to the floor. Client M was attempting to break a window.</p> <p>11/30/12: Client U was hitting her head on the wall and staff #28 was attempting to place her in a PRT and was injured. Staff #28's left little finger was dislocated.</p> <p>12/17/12: Client A was "going after another client (client J)" when staff #21 tried to intervene, client J tried to hit client A with a chair and client A "grabbed my hair pulling my hair out and pushing me up against the wall, starching (sic) my arm up."</p> | | | | |

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| | <p>12/17/12: Client A was being placed in a PRT and grabbed staff #4's hair. Staff #4 wrote, "she yanked and pulled my hair without relenting. At some point during the altercation she scratched my face on the right side underneath and to the side of my right eye. My glasses were also damaged. A large handful of my hair was removed from my head." No record of documented effective corrective action was available for review for this incident.</p> <p>An interview with the Administrative Team (Administrative Staff #1, #3, #4, #5, Behavior Support Coordinator #1, Health Service Coordinator #1, Transitional Team Coordinator, #1 and #2, Director #1 and Qualified Support Professional (QSP) #1 and #2) was conducted on 01/28/13 at 3:52 PM. The Administrative Team indicated prior to the clients' admissions they were aware of the fact that the clients admitted to the facility had a history of aggressive behaviors which required psychiatric medication and physical restraints. They indicated staff and clients have been injured by the aggressive behaviors which continue to occur at the current time. QSP #2 indicated the clients had a lot of behaviors which continued to occur and often resulted in injuries. She further indicated client behaviors were often a</p> | | | | | | |

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| | <p>result of another client's behavior when the environment gets loud or behaviors escalate.</p> <p>This federal tag relates to complaint #IN00122955.</p> | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G809 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 02/05/2013 | |
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| W000189 | <p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on observation, interview and record review for 2 of 10 sampled clients (A and I), the facility failed to ensure all staff were retrained in regard to monitoring/supervising clients while on visits together and/or knew what to do if clients wanted to have sex.</p> <p>Findings include: The facility's reportable incident reports, BIRS (Behavior Incident reports) and/or investigations were reviewed on 1/23/13 at 10:29 AM. The facility's 1/13/13 reportable incident report indicated "On 1-13-2013, it was reported to staff by [client A], individual, that she had sex with her boyfriend, [client I], while in the bathroom of the Canteen room. An internal investigation has occurred in which video footage was reviewed and statements were gathered. [Administrative staff #1], Executive Director and [administrative staff #2], Interim Director of Operations discussed the incident with [name of Bureau of Developmental Disability Services (BDDS) staff] on 1-16-13 as there were</p> | W000189 | <p>- The facility will ensure all staff are retrained in regard to monitoring/supervising clients while on visits together and/or know what to do if clients wanted to have sex.</p> <p>-The facility will ensure all staff who work with clients are retrained in regard to monitoring clients while on visits together and know what to do if clients desire to have sex; -“Client Sexual Relationships” policy (attachment #1) was approved by facility on 2/6/13 and Human Rights Committee on 2/8/13 approved with suggestion/HRC reapproved with suggestion on 2/14/13; -All staff working with clients will be <u>fully</u> trained by TTCs / QSPs / immediate supervisor from their discipline by 3/7/13; -QSPs/TTCs will continue to assure and routinely clarify related information for all staff working with a client receives training in regard to client</p> | 03/07/2013 | | | |

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| | <p>questions as to whether or not this was a reportable incident. Both individuals consented and neither of them has a guardian. [Name of BDDS staff] asked that we report the incident and [name of Adult Protections (APS) staff] from APS were also notified verbally. Investigation results were unable to substantiate if sexual intercourse has actually taken place due to a lack of video access to the bathroom. Staff [staff #11], who was monitoring the individuals during their visitation, was suspended and consequently terminated on 1-18 due to poor judgement of allowing these two individuals to spend time together in the restroom, although both were consenting adults and both requested to go into the restroom together."</p> <p>The facility's 1/14 and 1/15/13 Internal Investigation Report indicated "On 1-13-13, [client A and client I] (currently a couple) were in the Canteen room for an evening visit. Staff, [staff #11], was supervising the visit. Upon returning from the visit, [client A] stated to staff [staff #12] that she had sex that evening with her boyfriend, [client I] while in the Canteen room bathroom... I asked her where the staff was at, she told me that he (staff #11) was sitting in the chair and that he them permission to go into the bathroom (sic). I explained to [client A]</p> | | <p>monitoring to address interpersonal sexuality and overt sexual activity per facility policy. -Date to be fully implemented: 3/7/13</p> | | | | |

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| | <p>that she should have taken the sex Ed. (education) Classes that I have been talking to her about. She said okay and then she wanted to speak to the nurse about some things. On 1-14-2013, [client I] stated that he asked his staff on the evening of 1-13-2013 if he could go in the bathroom to have sex together (with his girlfriend). He also stated that he did have sex with his girlfriend in the bathroom and that both she and he consented to this act. [Client I] also stated that he did not use protection and has had sexual education training at [name of hospital] 5 weeks prior to admission at Warner Transitional Services. On 1-14-2013, [client A] gave the following statement 'On the evening of January 13, 2013 at approximately 9:00pm, I went to the canteen within my boyfriend, [client I], and his new staff. We were sitting in the canteen talking and listening to music. We were whispering to each other. I told [client I] that WTS is taking too long for the sex education classes. He told me that he can ask his new staff that just got out of orientation if we can go into the bathroom for the last 5 minutes of our personal visitation. We talked back and forth with each other for about 5 minutes trying to figure out who should be the one to ask the staff. Finally I spoke up. I asked him [the staff] if we could go in the bathroom alone for 5</p> | | | |

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| | <p>minutes. The staff asked us if we were our own guardians. We said yes. Then he asked us if it was in our programs. We said yes; but we were lying. The staff then saluted and said 'Go ahead. Let me know when you are done.' We had sex while we were in the bathroom...." The facility's investigation indicated the clients did not use any protection and they both indicated they had sexual intercourse. The facility's investigation indicated staff #11 admitted to allowing the clients to go into the bathroom for private time together. Client #11's 1/13/13 witness statement indicated staff #11 was to "monitor" clients A and I in the canteen area. Staff #11's witness statement indicated clients A and I were in the bathroom for 10 to 15 minutes. The facility's investigation indicated the facility's videotape indicated the clients were in the bathroom alone for 18 minutes and "...All clients should be supervised at least every 15 minutes...." The facility's "...Conclusion: [Clients I and A] both entered the Canteen bathroom together. Due to the fact that there is no video access in the bathroom, it could not be concretely substantiated that the two individuals had intercourse. [Staff #11], staff, exercised poor judgement in allowing this action to take place due to a lack of knowledge of the appropriate way to handle this situation</p> | | | | |

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| | <p>that arose. Staff [staff #11] did not seek information from the correct source as he sought information from the clients themselves as opposed to referring to their support plans or his supervisor...."</p> <p>The facility's recorded/audio tape was reviewed on 1/23/13 at 3:35 PM. The video/audio tape was of clients A and I and staff #11 in the Canteen room of the facility at 9:46 PM on 1/13/13. The video/audio tape indicated music was playing in the canteen which prevented the clients A and I's conversation from being heard. The video tape did indicate the clients were sitting in one area of the canteen and staff #11 was on the other side of the room looking at a magazine. Clients A and I could be seen talking/whispering to each other and looking over to staff. At 9:52 PM, the video indicated the clients cut the music off. The video indicated client A asked staff if they could spend the last 5 minutes of their visitation in the bathroom of the Canteen. The video/audio tape showed staff #11 asked clients A and I if this was in their program. The video/audio tape indicated both clients stated "Yes." Staff #11 saluted clients A and I and both clients walked into the Canteen bathroom and closed the bathroom door. Staff #11 sat in the Canteen room whistling, stood whistling and walked out of sight of the</p> | | | | |

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| | <p>camera at 9:57 AM at the door/entrance of the Canteen Room. Staff #11 could still be heard whistling even the staff could not be seen. Staff #11 then stated to the clients in the bathroom, "It is a little after 10." Client A responded "Ok." Client A could be heard moaning/making sounds, in the Canteen bathroom, with the door closed. At 10:04 PM, staff #11 stated "You got to wrap it up. Wrap it up." Client A again could be heard moaning and making sounds in the Canteen bathroom. At 10:07 PM, staff #1 stated "We got to roll. We got to roll." At 10:09 PM, Clients A and I came out of the bathroom dressed with client A trying to straighten out her hair with her hand. Clients A and I retrieved their items from the table and began to walk out of the Canteen room.</p> <p>Client A's record was reviewed on 1/23/13 at 5:00 PM. Client A's 1/14/13 Team Meeting Summary indicated "It was reported by [client A] that she and peer, [client I], had intercourse last night. Team is meeting to discuss what follow-up actions need to be taken...(6) QSP will reinforce to staff that WTS is a 24 hour supervision facility and that 2 peers of opposite sex are never to be left unattended out of staff's sight for any reason without the appropriate consent from authorized parties (i.e. QSP, TTC)."</p> | | | |

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| | <p>Interview with Safety and Security Professional (SSP) #1 and administrative staff #2 on 1/23/13 at 3:45 PM indicated staff #11 had a walkie talkie and phone in the Canteen. SSP #1 and administrative staff #2 indicated the staff should have called someone before allowing the clients to go into the bathroom.</p> <p>Interview with HSC #1, QSP #2 and TTC #1 on 1/28/12 at 12:10 PM, indicated clients A and I were boyfriend and girlfriend. TTC #1 and QSP #1 indicated facility staff allowed clients A and I to go into the bathroom together. TTC #1 indicated the facility did not substantiate intercourse had taken place with clients A and I as there were no cameras in the bathroom. QSP #2 indicated she spoke with facility staff to remind them clients needed to be supervised at all times. QSP #2 indicated she did not document her re-training with staff. TTC #1 indicated the facility was in the process of developing a policy and procedure in regard to sex between clients and the facility staff would be formally trained on the policy once it was completed.</p> <p>This federal tag relates to complaint #IN00122955.</p> | | | | | | |

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| W000227 | <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on interview and record review for 1 of 10 sampled clients (A), the client's interdisciplinary team failed to address the client's identified training need in regard to sexuality/relationships.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, BIRS (Behavioral Incident Reports) and/or investigations were reviewed on 1/23/13 at 10:29 AM. The facility's 1/13/13 reportable incident report indicated "On 1-13-2013, it was reported to staff by [client A], individual, that she had sex with her boyfriend, [client I], while in the bathroom of the Canteen room...."</p> <p>Client A's 1/14/13 typed witness statement indicated client I did not use a condom when they had sex. The typed statement also indicated client A had, at times, refused to take her birth control pills.</p> <p>Client A's record was reviewed on 1/23/13 at 5:00 PM. Client A's 1/14/13</p> | W000227 | <p>-the client interdisciplinary teams will address identified client training need in regard to sexuality/relationships.</p> <p>· QSPs / Behavioral Specialists will assess all client needs in regard to sexuality and relationships;</p> <p>· Training needs for sexuality and relationships per assessment will be identified as warranted into specific client programming;</p> <p>· Responsible Parties: QSP and Behavioral Specialists to assess clients and QSPs to incorporate into individual client ISPs'</p> <p>· To be completed by: 3/7/13</p> | 03/07/2013 | | | |

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| | <p>Team Meeting Summary indicated "It was reported by [client A] that she and peer, [client I], had intercourse last night. Team is meeting to discuss what follow-up actions need to be taken...."</p> <p>The 1/14/13 IDT note indicated the "...QSP (Qualified Support Professional) will speak to [client A] about the consequences of unprotected sex and will educate about the risk of STDs (sexually transmitted diseases)...."</p> <p>Client A's 12/12 Individual Support Plan (ISP) did not address and/or include a formal training objective in regard to sexuality/relationships as client A's ISP did not indicate the client was in a sexual education/class.</p> <p>Interview with client A on 1/22/13 at 4:00 PM indicated before she and client I could have sex, the facility indicated they would have to complete a sex education class. When asked if the client was in a sex education class, client A stated "No. Still don't have class."</p> <p>Interview with HSC #1, QSP #2 and TTC #1 on 1/28/13 at 12:10 PM, indicated clients A and I were boyfriend and girlfriend. TTC #1 and QSP #2 indicated client A was not involved in sexuality training as the men were currently receiving the training and the facility</p> | | | | | | |

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| | <p>wanted to keep the men and women's training separate.</p> <p>This federal tag relates to complaint #IN00122955.</p> | | | |

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| W000240 | <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on interview and record review for 2 of 10 clients (A and C), the clients' program plans failed to indicate how staff were to supervise a client at night to prevent self harm and to indicate how often facility staff were to conduct room checks/sweeps. A client's program plan failed to include specific guidelines/indicate what facility staff were to do when the client refused her medications/birth control pills.</p> <p>Findings include:</p> <p>1. The facility's reportable incidents, Behavior Incident Reports (BIRS) and/or investigations were reviewed on 1/23/13 at 10:29 AM. The reportable incident reports indicated the following:</p> <p>-11/9/12 "[Client C] was in her room and sent another client with a note for staff. [Client C] had written that she would be dead by morning. When staff went to her room to speak with [client C] they found a bra tied around her neck. She allowed staff to help her remove the bra. [Client C] told staff that her peer's constant behaviors were just too much, that this peer took all of staff's attention. [Client</p> | W000240 | <p>- clients A & C's program plans were amended to indicate how staff are to supervise an identified client at night to prevent self-harm and to indicate how often facility staff were to conduct room checks/sweeps.</p> <p>· HRC approval was obtained on 01/31/2013 and 02/08/2013.</p> <p>· For all clients: The Interdisciplinary Team will indicate in individual BSPs how they are to be monitored per his/her needs and situation, including conducting room checks/sweeps.</p> <p>· Approval will be obtained from the HRC, legal guardians/HCR or other court appointed advocate. Staff working with client(s) will be trained on the specifics of</p> | 03/07/2013 | | | |

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| | <p>C] said that she had swallowed pieces of her broken CD and pushed a pencil up into her private area and was referring to this rather than a needle. [Client C] was seen by the nurse and evaluated. The Doctor gave orders for her to be seen in the emergency room. She was also placed on Level 1 Suicide Precautions (arm length reach of staff at all times). The report from the ER (emergency room) found no evidence that she had swallowed any non-edible objects and could only state there may be a particle under the skin of her arm but they could not remove it but to follow-up orthopedist or surgeon if they felt it is necessary...." The 11/9/12 reportable incident report indicated when client C was placed on Level 1 Suicide Precautions, all of client C's belongings except clothing would be removed from the client's bedroom to prevent self harm. The reportable incident report indicated client C would have to sleep in an observation room, at night, to ensure she did not have access to any objects to harm herself with.</p> <p>A 11/22/12 follow-up report indicated client C was removed from Level 1 Suicide Precautions to Level 2 Suicide Precautions (within staff sight) until November 21, 2012 and placed on "self-harm observation (remain in staff's sight at all times). The follow-up report</p> | | <p>required monitoring before being implemented by the facility and facility staff. (Reference attachment #3)</p> <p>·Responsible Parties: Behavioral Services Coordinator / Treatment Team Coordinator</p> <p>Date to be implemented for all clients: 3/7/13</p> <p>- client's program plans will include specific guidelines to indicate what facility staff were to do when a client refuses medications/birth control pills.</p> <p>· Per IDT meeting on 2/12/13, with Client A present, it was agreed and contracted with Client A:</p> <p>§ Compliance to take medications/birth control. Additionally, Client A decided if for any reason this would not occur, it would be appropriate to implement the following:</p> <p>ü No Visitation with opposite sex peers for</p> | |

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| | <p>indicated "Self-Harm Observation: Per order from psychiatrist, client is to remain in staff's sight at all times, can have no personal items in her room, cannot wear hooded shirts or heavy jackets, or long sleeve shirts. Client is also restricted from all sharps and pens. Client cannot have plastic silverware and must keep arms out of shirt at all times. Client is able to sleep in own room again. She can keep objects and belongings in her room that she does not self harm with...."</p> <p>-12/18/12 "At approximately 10:14pm on 12/18/2012, [client C] was in her bedroom. Her roommate walked into the room and noticed that [client C's] hands and head were underneath the covers. She (roommate) asked her (client C) to take her hands out so that she could see them and [client C] refused. Her roommate then went to alert staff that she thought [client C] was 'up to something.' Staff immediately went into [client C's] room. When they entered, head was peeking out of the covers (sic). Staff asked her to remove her hands from under the covers. She complied. She showed her right arm which had a cut/scrape on the right wrist. She stated that she had pieces of broken plastic from her DVD player that she had inserted in there. She also said that she had swallowed some pieces of the same material. When staff</p> | | <p>one week (or if medically cleared by MD)</p> <p>ü All home visits (LOAs) will be denied until Client A is medically cleared by MD.</p> <p>· Client A, later that same day, requested to go back on IM birth control medication (Depo Provera 150mgs q 3 months)</p> <p>This agreement was added to the client's BSP and approved by the HRC (2/14/13) in the event that Client A reneges on the contract.</p> <p>o For potential additional clients who may be affected by deficiency noted above, their IDT team will immediately meet to discuss and remedy situation by conversing about alternate forms/routes of medications/birth control.</p> <p>· Nursing documentation of the medication administration records shows</p> | | | | |

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| | <p>had her take off the covers completely, they noticed she had abrasions to her neck where she had tied a cord to the DVD player around herself...."</p> <p>The facility's 12/27/12 follow-up report indicated client C was placed on Level 1 Suicide Precautions after the 12/18/12 incident occurred. The follow-up report indicated "...[Client C] had been taken off all of her precautions prior to this incident taking place; therefore she was not any program requiring her to be in staff sight at all times. She was under the care and supervision of staff with 15 minute checks when not in the milieu of the dayroom. Therefore, it is not appropriate to deem this an incident of neglect because staff were implementing appropriate supervision within the guidelines of her psychiatrist. Unfortunately, this situation has proven that this is not an appropriate type of supervision for her at this time and therefore WTS will continue to follow the precaution recommendations of [name of psychiatrist] as well as put other measures in place (removal of personal belongings from room) to provide a safe environment for [client C]...."</p> <p>Client C's record was reviewed on 1/23/13 at 11:26 AM. Client C's 9/17/12 Admission Review Form indicated client</p> | | <p>medication/birth control refusals. Repetitive refusals will be communicated to the IDT team for further action.</p> <p>Responsible parties: Health Services, Behavioral Services and Interdisciplinary Team</p> <p>Date to be implemented: 3/07/13</p> | | | | |

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| | <p>C was admitted to the facility on 9/21/12. The 9/17/12 admission form under the section entitled "Special Requirements" indicated "[Client C] has a history of self-harming behaviors, typically during the night & (and) when she is in a quiet room area. She should be closely monitored for scratching/cutting herself with objects & at night for attempting to tie things around her neck." The 9/17/12 form indicated client C "...Self harms by tying things around her neck, scratching herself with broken or sharp objects, inserting things into her vagina, banging her head...."</p> <p>Client C's 10/25/12 Behavioral Support Plan (BSP) indicated "...[Client C] has a longstanding mental health history characterized by mood instability, self injurious behavior, suicide attempts, physical aggression, and poor insight and judgement...." The 10/25/12 BSP indicated client C demonstrated self injurious behavior "...can be severe in nature'...Previously required continuous observation between the hours of 9:00p-7:00a (at name of previous placement)...." The BSP also indicated client C demonstrated "...Suicidal actions (Referral documents indicate [client C] came 'very close to succeeding 2 X's (times) in the last 4 years'). Broken CD's and inserted them into her 'private areas.'"</p> | | | |

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| | <p>Client C's 10/25/12 BSP indicated if "... [Client C] is unable/unwilling to use more appropriate coping skills for feeling stressed, upset, or depressed, staff may remind [client C] of the natural consequences of her behavior...For instance the loss of personal items that are deemed potentially dangerous [keys, pens, pencils, etc.] following an incident of self-abuse to ensure her personal safety, as this was previously requested by [client C] at her previous placement..." The 10/25/12 BSP indicated "...IF THE CRISIS BEHAVIOR IS SELF-HARM ([client C] is an imminent danger to herself)...1. When a crisis situation occurs with [client C], she will be immediately asked to go to the nearest 'Calm Space' (Isolation) until she can regain control of behavior. A. Whenever an isolation intervention is employed, staff will continuously observe [client C] during the duration of the isolation to ensure her safety, reinforce the appropriate behavior, complete appropriate documentation, and respond immediately to any harmful health or psychological reactions [client C] may experience...."</p> <p>Client C's IDT Notes indicated the following (not all inclusive):</p> <p>-10/29/12 "Placed on level 2 suicide</p> | | | | |

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| | <p>precautions due to statements of 'not feeling safe.' This does not seem to necessitate any precautions beyond her normal bed checks."</p> <p>-11/13/12 Remains on Level 1 suicide precautions."</p> <p>-11/14/12 Remains on Level 1 suicide precautions.</p> <p>-12/19/12 "She was agitated saying her QSP was lying to her because she doesn't have her new goals in the binder. She was p (sic) physically aggressive toward staff, hit staff and attempted to hit peer. Staff placed her in physical restrain (sic) to prevent injury to her self (sic) and others. She was self harm in her room tired (sic) cord round her neck, broken DVD player and have a scratch in her wrist. she (sic) slept in the observation room per the nurse for suicide watch."</p> <p>-12/26/12 "...team discussed removing everything from her room and consistent line of sight due to self harming behaviors."</p> <p>-12/28/12 "[Client C] was removed from suicide precaution; however it is the recommendation of her team that she remain on line of sight precaution continually. She has agreed to have her</p> | | | |

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| | <p>personal items removed from her bedroom for her safety." Client C's IDT did not specifically indicate if client C would be on line of sight precautions at night, in the client's bedroom. Also, client C's 12/28/12 IDT note and/or behavior plan did not indicate how often facility staff were to perform room sweeps/checks, as client C had access to items from other areas of the facility, to prevent incidents of self harm from occurring.</p> <p>Interview with Treatment Team Coordinator (TTC) #1, Behavior Support Coordinator (BSC) #1, QSP #1, #2 and the Health Service Coordinator (HSC) on 1/28/13 at 12:10 PM indicated client C demonstrated behaviors of self harm on 11/9/12 and 12/18/12. QSP #1 and BSC #1 indicated client C had been on continuous monitoring/supervision by staff at her previous placement due to the client's self-injurious behavior. BSC #1 indicated facility staff had been placed at the client's bedroom door, at night, at the client's previous placement. BSC #1 and QSP #1 indicated the client's psychiatrist removed the client from the continuous observation after the client was admitted to the facility as the client did not have any self harm attempts. TTC #2 and QSP #1 and BSC indicated client C was now on line of sight at all times since the</p> | | | | | | |

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| | <p>12/18/12 incident. TTC #1, BSC #1 and QSP #1 indicated client C was in line of vision prior to the 12/18 12 incident. TTC #1 then indicated client C was on 15 minute checks which was done with all the clients at WTS. TTC #1 and QSP #1 indicated client C's 10/12 BSP did not specifically indicate how facility staff were to monitor the client at night when the client was in her bedroom. QSP #1 and TTC #1 indicated client C's BSP did not indicate how often facility staff were to sweep the client's bedroom to prevent the client from obtaining/hiding objects retrieved from other parts of the building/facility.</p> <p>2. The facility's reportable incident reports, BIRS and/or investigations were reviewed on 1/23/13 at 10:29 AM. The facility's 1/13/13 reportable incident report indicated "On 1-13-2013, it was reported to staff by [client A], individual, that she had sex with her boyfriend, [client I], while in the bathroom of the Canteen room...."</p> <p>Client A's 1/14/13 typed witness statement indicated client I did not use a condom when they had sex. The typed statement indicated client A had, at times, refused to take her birth control pills.</p> <p>Client A's record was reviewed on</p> | | | | | | |

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| | <p>1/23/13 at 5:00 PM. Client A's 1/17/13 faxed order indicated client A's doctor ordered a blood pregnancy test on 1/17/13. The faxed order indicated a second test was to be conducted in another 24 hours to rule out client A being pregnant.</p> <p>Client A's January 2013 Medication Administration Record (MAR) indicated client A received Nortrel 7-7-7-28 1 tablet daily for birth control. The 1/13 MAR indicated client A refused to take her birth control pill on 1/14 and on 1/18/13.</p> <p>Client A's 1/14/13 Team Meeting Summary indicated "It was reported by [client A] that she and peer, [client I], had intercourse last night. Team is meeting to discuss what follow-up actions need to be taken...IDT discussed that they (IDT) think [client A] is intentionally trying to get pregnant...." The 1/14/13 IDT note also indicated the nurse would review the client's MAR to see often client A had refused her birth control pills, obtain a pregnancy test...."</p> <p>Client A's 1/11/13 Behavior Support plan (BSP) indicated the client had a targeted behavior of program refusals/noncompliance which included refusals of medication. Client A's 1/11/13 BSP did not include specific guidelines,</p> | | | | | | |

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| | <p>and/or specifically indicate what staff were to do when the client refused her medications/birth control pills.</p> <p>Interview with HSC #1 on 1/28/13 at 4:40 PM indicated client A had 3 medication refusals in January 2013. HSC #1 indicated when client A refused her birth control medications they doubled up the pills the next day.</p> <p>This federal tag relates to complaint #IN00122955.</p> | | | | |

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| W000264 | <p>483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.</p> <p>Based on observation, interview and record review for 10 of 10 sampled clients (A, B, C, D, E, F, G, H, I and J) and for 18 additional clients (K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, A1 and B2), the facility failed to have its Human Rights Committee reviewed its restrictive practice of using video/audio surveillance to ensure clients' rights and privacy were protected.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, BIRS (Behavior Incident Reports) and/or investigations were reviewed on 1/23/13 at 10:29 AM. The facility's 1/13/13 reportable incident report indicated "On 1-13-2013, it was reported to staff by [client A], individual, that she had sex with her boyfriend, [client I], while in the bathroom of the Canteen room...Investigation results were unable to substantiate if sexual intercourse has actually taken place due to a lack of video</p> | W000264 | <p>-The facility's Human Rights Committee will ensure the facility does not violate clients' rights in regard to privacy by reviewing, monitoring and making suggestions to the facility about its practices and programs as they relate to protection of client rights and funds and any other areas that the HRC believes need to be addressed. · Audio permission has been added to client/guardian/health care representative consent (attached #2) for surveillance of the commons areas, which had only video previously noted on the consent form. · Human Rights Committee has approved the audio addition to the video surveillance of the overall surveillance to the common areas of the facility</p> <p>Completed on: 1/31/13 Responsible Party who presented to HRC: Behavioral Services Coordinator; Clients, legal guardians and / or health care representatives</p> | 03/07/2013 | |

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| | <p>access to the bathroom. Staff [staff #11], who was monitoring the individuals during their visitation, was suspended and consequently terminated on 1-18 due to poor judgement of allowing these two individuals to spend time together in the restroom, although both were consenting adults and both requested to go into the restroom together."</p> <p>The facility's recorded/audio tape was reviewed on 1/23/13 at 3:35 PM. The video/audio tape was of clients A and I and staff #11 in the Canteen room of the facility at 9:46 PM on 1/13/13. The video/audio tape indicated music was playing in the canteen which prevented clients A and I's conversation from being heard. The video tape did indicate the clients were sitting in one area of the canteen and staff #11 was on the other side of the room looking at a magazine. Clients A and I could be seen talking/whispering to each other and looking over to staff. At 9:52 PM, the video indicated the clients cut the music off. The video indicated client A asked staff if they could spend the last 5 minutes of their visitation in the bathroom of the Canteen. The video/audio tape showed staff #11 asked clients A and I if this was in their program. The video/audio tape indicated both clients stated "Yes." Staff #11 saluted clients A and I and both</p> | | <p>will have the addition to the surveillance form presented to them for approval; Responsible Party: Admissions Coordinator Date to be completed with consents by: 3/7/13</p> | | |

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| | <p>clients walked into the Canteen bathroom and closed the bathroom door. Staff #11 sat in the Canteen room whistling, stood whistling and walked out of sight of the camera at 9:57 AM at the door/entrance of the Canteen Room. Staff #11 could still be heard whistling even the staff could not be seen. Staff #11 then stated to the clients in the bathroom, "It is a little after 10." Client A responded "Ok." Client A could be heard moaning/making sounds, in the Canteen bathroom, with the door closed. At 10:04 PM, staff #11 stated "You got to wrap it up. Wrap it up." Client A again could be heard moaning and making sounds in the Canteen bathroom. At 10:07 PM, staff #1 stated "We got to roll. We got to roll." At 10:09 PM, Clients A and I came out of the bathroom dressed with client A trying to straighten out her hair with her hand. Clients A and I retrieved their items from the table and began to walk out of the Canteen room.</p> <p>During the 1/22/13 observation period between 3:55 PM and 6:00 PM, at the facility, cameras were observed in the day room, hallways of the unit, hallways of the facility and in the dining room where clients A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z, A1 and B2 lived/resided.</p> | | | |

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| | <p>Client A's record was reviewed on 1/23/13 at 5:00 PM. Client I's 9/10/12 Individual Support Plan (ISP) indicated indicated client A was her own guardian. Client A's record and/or ISP did not indicate the facility's Human Rights Committee reviewed and/or approved the restrictive practice/rights violation.</p> <p>Client B's record was reviewed on 1/24/13 at 4:13 PM. Client B's 12/10/12 ISP indicated client B was his own guardian. Client B's 12/10/12 ISP did not indicate the facility's Human Rights Committee reviewed and/or approved the restrictive practice/rights violation.</p> <p>Client C's record was reviewed on 1/23/13 at 11:26 AM. Client C's 9/4/12 ISP indicated client C was her own guardian. Client C's 9/4/12 ISP did not indicate the facility's Human Rights Committee reviewed and/or approved the restrictive practice/rights violation.</p> <p>Client D's record was reviewed on 1/24/13 at 3:24 PM. Client D's 9/10/12 ISP indicated client D's step father was his legal guardian. Client D's 9/10/12 ISP</p> | | | | | | |

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| | <p>did not indicate the facility's Human Rights Committee reviewed and/or approved the restrictive practice/rights violation.</p> <p>Client E's record was reviewed on 1/23/13 at 1:24 PM. Client E's 10/23/12 Transition Support Plan (TSP) indicated client E was her own guardian. Client E's 10/23/12 TSP did not indicate the facility's Human Rights Committee reviewed and/or approved the restrictive practice/rights violation.</p> <p>Client F's record was reviewed on 1/25/13 at 1:45 PM. Client F's undated TSP indicated client F's parents were her legal guardians. Client F's undated TSP did not indicate the facility's Human Rights Committee reviewed and/or approved the restrictive practice/rights violation.</p> <p>Client G's record was reviewed on 1/24/13 at 2:31 PM. Client G's 10/25/12 ISP indicated client G was his own guardian. Client G's 10/25/12 ISP did not indicate the facility's Human Rights Committee reviewed and/or approved the restrictive practice/rights violation.</p> | | | |

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| | <p>Client H's record was reviewed on 1/24/13 at 1:06 PM. Client H's 12/10/12 ISP indicated client H had a legal guardian. Client H's record 12/10/12 ISP did not indicate the facility's Human Rights Committee reviewed and/or approved the restrictive practice/rights violation.</p> <p>Client I's record was reviewed on 01/24/13 at 11:06 AM. Client I's 8/20/12 ISP indicated client I was his own guardian. Client I's 9/10/12 ISP did not indicate the facility's Human Rights Committee reviewed and/or approved the restrictive practice/rights violation.</p> <p>Client J's record was reviewed on 1/25/13 at 10:20 AM. Client J's 12/7/12 TSP indicated client J was her own guardian. Client J's 12/7/12 TSP did not indicate the facility's Human Rights Committee reviewed and/or approved the restrictive practice/rights violation.</p> <p>Interview with TTC #1 and #2 on 1/23/13 at 3:00 PM indicated sounds could be heard coming from the bathroom during the 1/13/13 incident upon review of the</p> | | | | |

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| | <p>audio tape.</p> <p>Interview with Safety and Security Professional (SSP) #1 and administrative staff #2 on 1/23/13 at 3:45 PM indicated there was a microphone located on the camera in the Canteen room. SSP #1 indicated the cameras throughout the entire facility all had microphones on them. SSP #1 stated "The audio was only on when needed." The SSP indicated when the video recorded footage audio would also be recorded. The SSP indicated all security personnel had access to the cameras/audio when monitoring the building/facility and when conducting investigations. SSP #1 indicated the facility had a total of 180 cameras located throughout the facility.</p> <p>Interview with administrative staff #1 on 1/28/13 at 3:59 PM indicated the facility utilized video and audio surveillance. Administrative staff #1 indicated the cameras were located in the common areas of the facility. Administrative staff #1 indicated there were no cameras in the clients' bedrooms, bathrooms, therapist offices, QSPs office, Behavior Specialist office, staff lounges and the conference room. Administrative staff #1 indicated the audio could not pick up conversations. Administrative staff #1 indicated the cameras with audio capabilities had been</p> | | | | | | |

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| | installed in the building prior to the opening of the facility in August 2012. Administrative staff #1 indicated the facility's Human Rights Committee had not reviewed the facility's restrictive practice/usage of the video/audio surveillance to ensure the protection of the clients' rights. | | | |

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| W000267 | <p>483.450(a)(1) CONDUCT TOWARD CLIENT The facility must develop and implement written policies and procedures for the management of conduct between staff and clients. Based on interview and record review for 1 of 10 sampled clients (A), the facility failed to implement its written policy and procedures to ensure a professional staff spoke to a client in a respectful/dignified manner in regard to a sexual incident which occurred at the facility.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, BIRS (Behavior Incident Report) and/or investigations were reviewed on 1/23/13 at 10:29 AM. The facility's 1/13/13 reportable incident report indicated "On 1-13-2013, it was reported to staff by [client A], individual, that she had sex with her boyfriend, [client I], while in the bathroom of the Canteen room. An internal investigation has occurred in which video footage was reviewed and statements were gathered...Staff [staff #11], who was monitoring the individuals during their visitation, was suspended and consequently terminated on 1-18 due to poor judgement of allowing these two individuals to spend time together in the restroom, although both were consenting adults and both requested to go into the</p> | W000267 | <p>-The facility has developed and implemented written policies and procedures for the management of conduct between staff and clients o Incident referenced in the POC W 267 was specifically reviewed with the professional staff member referenced. Therapy summary notes had been inadvertently submitted to the ISDOH surveyors along with the separate investigation report. · therapy notes / staff client interaction was correctively reviewed with the professional staff by the Director of Operations on 2/14/13 · Policy – “Employee Conduct” (attachment # 6) will be reviewed with the staff member indicated by TTC (supervisor) by: 3/7/13 o The QSP staff are no longer performing investigations for their own clients; · Investigative staff have been put into place and trained on investigations by Quality Assurance Dir. · Additional training on investigations was provided on 2/14/13 by S. Corya of ISDOH · Completed/fully implemented: 2/18/13</p> | 03/07/2013 | |

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| | <p>restroom together."</p> <p>The facility's 1/14 and 1/15/13 Internal Investigation Report indicated "On 1-13-13, [client A and client I] (currently a couple) were in the Canteen room for an evening visit. Staff, [staff #11], was supervising the visit. Upon returning from the visit, [client A] stated to staff [staff #12] that she had sex that evening with her boyfriend, [client I] while in the Canteen room bathroom... I asked her where the staff was at, she told me that he (staff #11) was sitting in the chair and that he then permission to go into the bathroom (sic). I explained to [client A] that she should have taken the sex Ed. (education) Classes that I have been talking to her about. She said okay and then she wanted to speak to the nurse about some things. On 1-14-2013, [client I] stated that he asked his staff on the evening of 1-13-2013 if he could go in the bathroom to have sex together (with his girlfriend). He also stated that he did have sex with his girlfriend in the bathroom and that both she and he consented to this act. [Client I] also stated that he did not use protection and has had sexual education training at [name of hospital] 5 weeks prior to admission at Warner Transitional Services. On 1-14-2013, [client A] gave the following statement 'On the evening</p> | | | | | | |

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| | <p>of January 13, 2013 at approximately 9:00pm, I went to the canteen within my boyfriend, [client I], and his new staff. We were sitting in the canteen talking and listening to music. We were whispering to each other. I told [client I] that WTS is taking too long for the sex education classes. He told me that he can ask his new staff that just got out of orientation if we can go into the bathroom for the last 5 minutes of our personal visitation. We talked back and forth with each other for about 5 minutes trying to figure out who should be the one to ask the staff. Finally I spoke up. I asked him [the staff] if we could go in the bathroom alone for 5 minutes. The staff asked us if we were our own guardians. We said yes. Then he asked us if it was in our programs. We said yes; but we were lying. The staff then saluted and said 'Go ahead. Let me know when you are done.' We had sex while we were in the bathroom...." The facility's investigation indicated the clients did not use any protection and they both indicated they had sexual intercourse. The facility's 1/14 and 1/15/13 investigation indicated " ...Upon returning back to the unit, I (client A) that I had vaginal bleeding. The nurse was notified and examined my private area. She also provided me with information on sexually transmitted diseases. Also on 1-14-12013, when asked, [client A] stated</p> | | | | | | |

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| | <p>that she has had sexual education training three times prior to coming to Warner Transitional Services...." The facility's investigation indicated staff #11 admitted to allowing the clients to go into the bathroom for private time together.</p> <p>Client A's 1/14/13 typed witness statement indicated client I did not use a condom when they had sex. An attached undated typed question and answer statement (part of the 1/14/ and 1/15/13 investigation) of client A with QSP #2 indicated the following (not all inclusive):</p> <p>"...QSP: You two intentionally violated the boundaries of your relationship that were approved by both you and your IDT Teams, (sic) you admitted that you knew you were not suppose (sic) to have sex which is why you lied to the new staff, you had intercourse on the floor of a public bathroom, you did not use a condom during intercourse, and you admitted that you have refused your birth control medications several times in the last month. Do you feel like this was demonstrating 'safe sex?'</p> <p>[Client A]: No...</p> <p>QSP: Are you purposely trying to get pregnant?</p> | | | | | | |

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| | <p>[Client A]: No. We want to have kids but I was not trying to get pregnant right now.</p> <p>QSP: Why did you take all your medications this morning; but refused only your birth control?</p> <p>[Client A]: Because I might be pregnant. I don't want the baby to get a birth defect.</p> <p>QSP: What do you think is going to happen to you if you have a baby? Where will you go? Children are not allowed in this facility?</p> <p>[Client A]: I'm going to go to my aunt's house. She will help me.</p> <p>QSP: How are you going to afford to raise a baby? Children are expensive and you do not have a job. You only get \$10.00 a week for your budgeted income. You could not afford to buy a stamp to mail a letter last week-how are you going to pay for diapers, formula, baby clothes, medical bills, etc...?</p> <p>[Client A]: I don't know.</p> <p>QSP: And how are you going to explain to your baby where his daddy is? Just because you might leave if you have a baby doesn't mean that [client I] can go too...."</p> | | | |

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| | <p>Client A's record was reviewed on 1/23/13 at 5:00 PM. Client A's 1/14/13 Team Meeting Summary indicated "It was reported by [client A] that she and peer, [client I], had intercourse last night. Team is meeting to discuss what follow-up actions need to be taken...IDT discussed that they (IDT) think [client A] is intentionally trying to get pregnant...." The IDT note indicated "... (5) QSP will speak with [client A] about the consequences of unprotected sex and will educate about the risk of STDs (sexually transmitted diseases)...."</p> <p>The facility's policy and procedures were reviewed on 1/22/13 at 3:00 PM. The facility's June 2012 policy entitled Employee Conduct indicated "Function: To define guidelines for appropriate staff interaction with Warner Transitional Services (WTS) clients...." The policy indicated "...WTS staff will not engage in verbal abuse with or direct verbal abuse at the clients. Verbal abuse is defined as but is not limited to ...making derogatory statements ...that may cause damage to an individual's self respect or dignity...."</p> <p>The facility's 8/12 revised policy entitled Reporting and Investigations indicated "...Employees, agents, and volunteers must treat clients and other individuals</p> | | | | |

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| | <p>with dignity and respect...."</p> <p>Interview with Treatment Team Coordinators #1 and #2 on 1/23/13 at 3:00 PM indicated staff should treat clients with dignity and respect.</p> <p>This federal tag relates to complaint #IN00122955.</p> | | | |

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| W000286 | <p>483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used for disciplinary purposes. Based on interview and record review for 1 of 10 sampled clients (F), the facility failed to ensure a client was not disciplined for eloping in the community due to the facility's lack of supervision/monitoring.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 1/23/13 at 10:29 AM. The facility's 1/8/13 reportable incident report indicated client F had an appointment at a government office where the client was in a good mood. The 1/8/13 reportable incident report indicated "...While on the ride home, at approximately 2:20 pm, [client F] had made up an elaborate, detailed story of her social history stating that she was adopted and that her late maternal grandmother was her 'real' mother...When we were about 10 minutes away from returning to the WTS facility, the QSP (Qualified Support Professional) looked over and saw that [client F's] entire affect had changed. She was visibly agitated for an unknown reason. QSP asked [client F] if she was okay, and</p> | W000286 | <p>-the facility will ensure clients are not disciplined for eloping in the community due to the facility's lack of supervision/monitoring. o Following the incident noted above, an IDT meeting was conducted (1/10/13) to review the events leading up to the occurrence noted and relevant recommendations. Client F's legal guardians participated via phone conference. Per Client F's legal guardian's request and agreement with ID team, Client F "...would not be allowed to leave the facility except for necessary medical appointments. During this period, Client F will be transported by two staff. A third staff will act as the driver. Client F will only sit in the back of the vehicle in a seat that is not directly behind the driver. After three months, (at Client F's quarterly ISP meeting) participants will evaluate if it is appropriate for Client F to leave the facility for programming activities, such as shopping with Life Skills instructor..." o HRC approved: 1/11/31. o On 2/19/13, Client F had quarterly</p> | 02/05/2013 | | | |

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| | [client F] responded with vulgar profanity and said she did not want to talk to her QSP. QSP replied that's okay and that we're almost back so she can have some private time when we get there to help relieve some of her anxiety. When the vehicle was about 5 minutes away from the facility, [client F] took her family photos out of her purse and started ripping her photo into many little pieces. Then she took a CD case and started to break the case. QSP removed the CD case from [client F] for fear that [client F] was going to harm herself with it. Immediately [client F] became physically aggressive towards her QSP (who was driving) and was continuously throwing punches to the QSP's face and right arm. QSP was able to block most of the hits with her right arm and pushed [client F] off of her. QSP informed [client F] that she was driving and that that was not safe for either one of them. In turn, [client F] tried to pull the shifter out of gear while the vehicle was in motion. Once again, QSP reminded [client F] that it was not safe to do that and that they were almost back to the facility. While they were on [name of busy street], less than a mile from WTS, [client F] reached over and pulled the entire steering wheel towards the passenger side which caused the vehicle to swerve into the other lane of traffic. There were no cars in that lane at that | | ISP meeting. Client F's legal guardians were present in person for this meeting. Discussion of increased community access was presented. Again, Client F's legal guardians did not believe it would be in the client's best interest to lessen the current restriction re: community outings and decided to revisit the idea at Client F's next ISP meeting. - For all clients behavior management will not be used for disciplinary reasons; - Responsible Parties: Interdisciplinary Treatment Team - Date: 1-11-31 | | | | |

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| | <p>time. QSP attempted to call WTS for assistance to come outside to help when they arrived, but [client F] began hitting the QSP again and then opened the passenger side door. She leaned out of the door, however she had her seatbelt on as a restraint. QSP had grabbed on to her jacket and pulled her back into the vehicle. She tried to take off her seatbelt, but QSP held it in the socket with the right hand and continued to steer the vehicle with the left hand. [Client F] had climbed out of her seatbelt. QSP made the call at that point to bring the vehicle to a stop since [client F] was no longer secured in the car. [Client F] opened the door and jumped out of the vehicle while it was still in motion. The QSP got out of the car and yelled for [client F] who was running down the middle of [name of busy street] towards oncoming traffic. At 2:28 pm, the QSP had WTS on the phone at this time to send out emergency assistance to help retrieve [client F]. Two DSPs (Direct Support Professionals) and a LDSP (Lead Direct Support Professional) joined the QSP within 2 minutes and they drove south on [name of busy street] towards the direction [client F] had eloped. A car on the opposite side of the road had flagged down the vehicle. An off-duty staff that works on the hall with [client F] was coincidentally driving down the same street with her mother on</p> | | | |
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| | <p>the way to the grocery store when she had seen [client F] running. She pulled over and [client F] voluntarily got in her car. QSP and other staff pulled up to the vehicle. [Client F] was sitting in the backseat crying. (She had also broken her glasses while she was running.) Later in the evening, [client F] was describing the events of the day to a Safety and Security Professional and [client F] kept referring to the incident as 'Happy feet.'...Immediate: There is an emergency IDT meeting scheduled for [client F] on Thursday January 10, 2013 to discuss this event and make revisions as deemed necessary to her Behavior Support Plan. [Client F's] guardians will be participating via phone conference...."</p> <p>Client F's record was reviewed on 1/25/13 at 1:45 PM. Client F's 11/26/12 Transitional Behavioral Support Plan (TBSP) indicated client F was admitted to the facility on 11/26/12. The 11/26/12 TBSP indicated client F demonstrated the targeted behavior of elopement which was defined as "...Leaving designated area or staff supervision without permission. Previous placement reports that [client F] enjoys going to the doctor and will often NOT elope during doctor appointment outings, but must be closely supervised on all other outings. [Client F] has a history of attempting to manipulate staff to create</p> | | | | | | |

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| | <p>an opportunity to elope. Last incident of attempted elopement was in March 2012...."</p> <p>Client F's 1/2/13 Behavior Support Plan (BSP) Level 1 "Proactive or Preventative Strategies" section indicated "...5. Due to [client F's] history of elopement, impulsiveness, and self-harming behaviors, supervision requirements necessary for her to participate in community activities and off-ground activities include she is to be within line of sight and arm's reach of staff at all times. To reduce elopement while on community outings, [client F] will be transported by one staff who is designated as the driver and another staff who will monitor [client F]. [Client F] will sit in the back seat of the vehicle and will not sit behind the driver of the vehicle. Last documented incident of elopement was in March 2012...."</p> <p>An attached BSP addendum to the 1/2/13 BSP dated 1/11/2013 indicated "[Client F] has the potential to elope while on community outings, and had an incident of elopement on 1/8/2013. Since she acts in an impulsive manner, she places herself in a situation which could cause serious injury to herself and others. For three months, [client F] will only leave the facility for necessary medical</p> | | | |

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| | <p>appointments. During this period, [client F] will be transported by two staff. A third staff will act as the driver. [Client F] will only sit in the back of the vehicle in a seat that is not directly behind the driver. After three months, [client F's] IDT will evaluate if it is appropriate for her to leave the facility for programming activities, such as shopping with her Life Skills instructor. After six months, [client F's] IDT will evaluate the appropriateness of restoring full privileges allowing [client F] to participate in community outings with appropriate staff supervision...."</p> <p>The facility failed to implement/follow client F's 1/2/13 BSP in regard to sending 2 staff, during transport with client F, to the scheduled appointment in the community which resulted in client F placing herself and staff in danger in the van, and in regard to client F's elopement from a moving vehicle. The facility failed to monitor/supervise client F adequately in the community which resulted in client F being disciplined/restricted from community outings/activities.</p> <p>Client F's record was reviewed on 1/25/13 at 1:45 PM. Client F's 1/2/13 Behavior Support Plan (BSP) indicated client F demonstrated physical aggression, verbal aggression, self harming behavior,</p> | | | |

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| | <p>property destruction, inappropriate sexual behavior, manipulating/attention seeking behavior and elopement.</p> <p>Interview with QSP #2, TTC #1 and BSC #1 on 1/28/13 at 12:10 PM indicated client F had a history of elopement. QSP #2 indicated she was with client F on 1/8/13 when the incident occurred. QSP #2 indicated she was the only staff in the van with client F. QSP #2 indicated client F did fine until they were returning from the facility from her appointment in the community. QSP #2 stated "Within 30 seconds demeanor and affect changed. Can't say what triggered her." QSP #2 stated client F turned the volume up in the van, ripped her pictures she had in her purse, hit QSP #2, "busted" a CD case and hit QSP #2 with a purse. QSP #2 stated she did not stop and/or pull over as she knew client F was "an elopement risk." QSP #2 stated client F "turned wheel (steering) into traffic" and opened the vehicle door. QSP #2 indicated client F eloped from the vehicle and ran down the street where an off duty staff saw/found the client. QSP #2 stated at the IDT meeting, "She (client F) had no awareness or concern at meeting" in regard to what she had done on 1/8/13. When asked how client F's restrictions came about, QSP #2 stated client F's "Getting out of vehicle to do that was a</p> | | | |

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| | <p>safety risk of going out into traffic." QSP #2 stated client F would need to demonstrate "appropriate behavior" before the client would be allowed to participate in community activities/outing. QSP #2 indicated client F being allowed to go back out into the community was based on the client's targeted behaviors (not demonstrating) in her 1/2/13 BSP.</p> <p>The facility's policy and procedures were reviewed on 1/23/13 at 3:00 PM and at 5:12 PM. The facility's 8/12 revised policy entitled Reporting and Investigations indicated "It is the policy of Warner Transitional Services (WTS) to protect individuals who may be vulnerable to abuse, neglect or exploitation, mistreatment, or a violation of client rights...." The policy indicated "...If an allegation of abuse or neglect is made, the Qualified Support Professional (QSP) or Safety/Security Professional (SSP) will ensure the individual is moved to a safe location. The QSP or SSP will notify all appropriate WTS staff including the Executive Director/Administrator who is responsible for ensuring that all investigations are completed thoroughly and that records of the investigation are maintained...." The facility's June 2012 policy entitled Employee Conduct indicated "Each person receiving services</p> | | | | | | |

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| | <p>from WTS will receive humane care and protection from harm...." The policy indicated clients had the right to be free from neglect and/or punishment.</p> <p>This federal tag relates to complaint #IN00122955.</p> | | | |

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| W000289 | <p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on interview and record review for 1 of 10 sampled clients (J) with restrictive programs, the facility failed to include the use of a Modified restraint in the client's program.</p> <p>Findings include:</p> <p>Client J's record was reviewed on 1/25/13 at 10:20 AM. Client J's Behavioral Incident Reports (BIRS) indicated the following:</p> <p>-1/18/13 at 6:54 AM, client J was placed in a Modified sitting PRT (Primary Restraint Technique) for punching a wall without redirection.</p> <p>-1/18/13 at 7:06 AM, client J was placed in a Modified Sitting PRT as the client continued to punch a wall.</p> <p>-1/18/13 at 11:43 PM, client J "...suddenly hit the staff and attempted to continue fighting. Staff placed her in a modified sitting PRT."</p> | W000289 | <p>-the facility has addressed the use of systematic interventions to manage inappropriate client behavior and has incorporated these into the client's individual program plan</p> <p>-Client J's BSP has been amended and approved by HRC to include the use of specific PRT (Handle With Care) due to complaint of shoulder pain, included were Two Person Escort and Modified PRT on 01/31/2013. (Currently, staff working with Client J, have been trained on proper use of 'modified PRT').</p> <p>o Responsible Parties: Behavioral Service Coordinator / Treatment Team Coordinator / and Qualified Support Professional</p> <p>o Date Completed and Implemented: 02/06/13</p> <p>o For all clients, the Interdisciplinary Team will indicate in their individual BSPs how they are to be monitored per his/her needs and situation.</p> <p>o Approval will be obtained from the HRC, legal guardians/HCR or other court appointed advocate. Staff working with client(s) will</p> | 02/06/2013 |
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| | <p>-1/15/13 at 9:14 PM, client J went up to client Y and punched client Y in the back and in the client's head. Client J was placed in a Modified Standing PRT.</p> <p>Client J's 12/28/12 Nursing Progress Notes indicated "Received new order; okay use Modified PRT (Primary Restraint technique) technique when necessary (sic)." Client J's 12/28/12 Fax indicated the nurse had requested the use of a Modified restraint due to the client's complaint of shoulder pain.</p> <p>Client J's 11/26/12 Behavioral Support Plan (BSP) did not include the use of Modified PRT.</p> <p>Client J's interdisciplinary team notes from 11/13/12 to 12/28/12 did not indicate the facility incorporated the use of a Modified PRT into the client's BSP.</p> <p>Interview with Health Services Coordinator (HSC) #1, TTC #1 and QSP #2 on 1/28/13 at 12:10 PM indicated client J complained of pain in her left shoulder. HSC #1 and TTC #1 indicated staff were using a Modified standing and/or sitting PRT with the client. TTC #1 stated the modified restraint held the client's arms down to her side and/or in front of the client like a "baskethold."</p> | | <p>be trained on the specifics of required monitoring before being implemented by the facility and facility staff. o</p> <p>Responsible Parties:</p> <p>Behavioral Services Coordinator / Treatment Team Coordinator o</p> <p>Date to be Implemented for all clients, as assessment/need demonstrates and approval is obtained: On-going from 2/6/13.</p> | | |

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| | This federal tag relates to complaints #IN00122083 and #IN00122955. | | | |

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| W000331 | <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on interview and record review for 2 of 10 sampled clients (A and J), the nursing services failed to meet the nursing needs of the clients.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, BIRS (Behavior Incident Reports) and/or investigations were reviewed on 1/23/13 at 10:29 AM. The facility's 1/13/13 reportable incident report indicated "On 1-13-2013, it was reported to staff by [client A], individual, that she had sex with her boyfriend, [client I], while in the bathroom of the Canteen room. An internal investigation has occurred in which video footage was reviewed and statements were gathered...."</p> <p>The facility's 1/14 and 1/15/13 Internal Investigation Report indicated "On 1-13-13, [client A and client I] (currently a couple) were in the Canteen room for an evening visit. Staff, [staff #11], was supervising the visit. Upon returning from the visit, [client A] stated to staff [staff #12] that she had sex that evening with her boyfriend, [client I] while in the Canteen room bathroom... I asked her</p> | W000331 | <p>-the facility must provide clients with nursing services in accordance with their needs. · Client A states she reported Vaginal bleeding after intercourse to nursing staff. However, nursing staff was unaware of the situation at the time of the alleged bleeding and no assessment was completed. · In the event any incident that would require a nursing assessment or treatment occurs, the wellness clinic/nursing staff will be notified. Documentation of assessments completed will be written in the clients nursing progress notes. · LDSP will be responsible for initiating the call to the nurse when an assessment is required. Protocol/Guidelines will be established of when to notify the nurse. · Any atypical assessments conducted will be reported by nurses to the Health Services Coordinator for follow-up/trending. In the event of any found trends, these will be reported to QA. · Changes Implemented by 3/7/13</p> <p>·For all clients nurse will immediately assess clients with known medical needs,</p> | 03/07/2013 | | | |

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| | <p>where the staff was at, she told me that he (staff #11) was sitting in the chair and that he then permission to go into the bathroom (sic). I explained to [client A] that she should have taken the sex Ed. (education) Classes that I have been talking to her about. She said okay and then she wanted to speak to the nurse about some things...On 1-14-2013, [client A] gave the following statement 'On the evening of January 13, 2013 at approximately 9:00pm, I went to the canteen with my boyfriend, [client I], and his new staff. We were sitting in the canteen talking and listening to music. We were whispering to each other. I told [client I] that WTS is taking too long for the sex education classes. He told me that he can ask his new staff that just got out of orientation if we can go into the bathroom for the last 5 minutes of our personal visitation. We talked back and forth with each other for about 5 minutes trying to figure out who should be the one to ask the staff. Finally I spoke up. I asked him [the staff] if we could go in the bathroom alone for 5 minutes. The staff asked us if we were our own guardians. We said yes. Then he asked us if it was in our programs. We said yes; but we were lying. The staff then saluted and said 'Go ahead. Let me know when you are done.' We had sex while we were in the bathroom...." The facility's</p> | | <p>conditions and medical devices, including implants; -Responsible Parties: o Health Services Coordinator (DON) will assure client medical needs are addressed in a timely and responsive fashion by 2/6/13; o Health Services Coord. to train nurses on proper documentation, including follow-up to any medical intervention / assessment completing the revised "Client Injury Report" (attached # 7) with follow-up by 2/6/13; o Health Services Coord. to train nurses on revised "Physical Restraint Policy" (attached # 8), to include focus on immediately assessing those clients with known medical conditions / medical devices by 2/6/13</p> | | | | |

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| | <p>investigation indicated the clients did not use any protection and they both indicated they had sexual intercourse. The facility's 1/14 and 1/15/13 investigation indicated" ...Upon returning back to the unit, I (client A) noticed that I had vaginal bleeding. The nurse was notified and examined my private area. She also provided me with information on sexually transmitted diseases...."</p> <p>Client A's record was reviewed on 1/23/13 at 5:00 PM. Client A's Nursing Progress Notes from 1/1/13 to 1/21/13 indicated the facility's nurses did not document an assessment of client A in regard to the vaginal bleeding and/or to obtain a physical assessment of the client due to the nature of the incident.</p> <p>Client A's 1/17/13 faxed order indicated client A's doctor ordered a blood pregnancy test on 1/17/13. The faxed order indicated a second test was to be conducted in another 24 hours to rule out client A being pregnant. On 1/23/13, client A's record did not indicate any documentation and/or results in regard to the blood pregnancy test as of 1/23/13.</p> <p>Client A's January 2013 Medication Administration Record (MAR) indicated client A received Nortrel 7-7-7-28 1 tablet daily for birth control. The 1/13 MAR</p> | | | | | | |

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| | <p>indicated client A refused to take her birth control pill on 1/14 and on 1/18/13. Client A's nursing progress notes did not indicate the facility's nurses documented any medication refusals in the nurse notes.</p> <p>Interview with client A on 1/22/13 at 4:00 PM indicated client A and client I had sex on the bathroom floor in the Canteen room. Client A indicated she felt she may be pregnant as she had missed some of her birth control pills. Client A indicated a pregnancy test had been done.</p> <p>Interview with HSC #1, QSP #2 and TTC #1 on 1/28/12 at 12:10 PM, indicated clients A and I were boyfriend and girlfriend. HSC #1 indicated she was not sure if a nurse assessed client A after the allegation was made. HSC #1 indicated she was not aware of the vaginal bleeding as she was not at the facility at that time. HSC #1 indicated if there was an assessment, nursing staff should have documented the assessment. QSP #2 and HSC #1 indicated client A's pregnancy tests indicated the client was not pregnant.</p> <p>Interview with HSC #1 on 1/28/13 at 4:40 PM indicated client A had 3 medication refusals in January 2013. HSC #1 indicated when client A refused her birth control medications they doubled up the</p> | | | | |

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| | <p>pills the next day.</p> <p>2. The facility's reportable incident reports and/or investigations were reviewed on 12/18/12 at 11:28 AM. The facility's 11/16/12 reportable incident report indicated "[Client J] complained of pain in her left shoulder to nurse at 12:00 PM on 11/15/2012. Nurse then contacted [client J's] primary care physician and he ordered an x-ray to be completed on her left shoulder. Mobile x-ray technician came to the facility and performed an x-ray at 2:07 AM on 11/12.2012 (sic). Results from the x-ray state: 'There is a suggestion of a fracture of the distal third of the clavicle with no displacement of the left shoulder. The acromioclavicular and coracoclavicular joints are normal.' Conclusion from the radiologist performing the examination stated: 'Questionable clavicle fracture as described above. Dedicated clavicle series recommended'...."</p> <p>The facility's 11/21/12 follow-up report indicated "Results of the dedicated clavicle series state: '2 views of the left clavicle demonstrate no fracture, dislocation or bony reaction. Acromioclavicular articulation is normal.' The conclusion from the radiology report states: 'No fracture or dislocation in clavicle.' [Client J] notified staff that she</p> | | | | | | |

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| | <p>has had issues with injuring her shoulder in the past. Physical therapy appointment was scheduled by WTS to further provide support for [client J's] symptoms. The initial evaluation by the therapist was completed on 11/20/2012 and states 'demonstrates weakness and decreased range of motion.' [Client J] was given four exercises by the physical therapist to do at WTS, three times a day, using a rolled up towel. Staff will assist [client J] in completing these exercises...."</p> <p>Client J's record was reviewed on 1/25/13 at 10:20 AM. Client J's Behavioral Incident Reports (BIRS) indicated the following:</p> <p>-1/18/13 at 6:54 AM, client J was placed in a Modified sitting PRT (Primary Restraint Technique) for punching a wall without redirection.</p> <p>-1/18/13 at 7:06 AM, client J was placed in a Modified Sitting PRT as the client continued to punch a wall.</p> <p>-1/18/13 at 11:43 PM, client J "...suddenly hit the staff and attempted to continue fighting. Staff placed her in a modified sitting PRT."</p> <p>-1/15/13 at 9:14 PM, client J went up to client Y and punched the client Y in the</p> | | | | |

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| | <p>back and in the client's head. Client J was placed in a Modified Standing PRT.</p> <p>Client J's 12/28/12 fax indicated "[Client J] has c/o (complaints of) shoulder pain. We would like to have you evaluate her tomorrow. But in the mean time, may we have an order to PRT her when necessary until your evaluation. Even if physical restraint technique is Modified because of her shoulder pain...." Client J's doctor responded on 12/28/12 "Ok for above." Client J's 12/28/12 fax order indicated "May use Modified PRT restraint technique when necessary d/t (due to) shoulder pain per [name of doctor]."</p> <p>Client J's 12/29/12 Progress Note by client J's doctor indicated "1. Patient has complained of Left Shoulder pain, history of Left Shoulder injuries chronically...2. Left shoulder won't be moved due to 'pain.' Won't abduct or rotate (without) pain. 3. MRI of Left Shoulder Needed Needed (sic)."</p> <p>Client J's 1/28/13 MRI report indicated client J had an "old healed fracture of the distal clavicle" with no additional abnormalities.</p> <p>Client J's Nursing Progress Notes indicated the following (not all inclusive):</p> | | | | | | |

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| | <p>-12/28/12 "Received new order; okay use Modified PRT technique when necessary (sic)."</p> <p>-12/29/12 Client Assessed (sic) by [name of doctor] Related to LT (left) shoulder. New order (1) MRI LT shoulder D/T pain chronic (2) Aspercreme Apply Q (every) 3 hrs (hours) PRN (as needed) Pain (sic)." The facility's nursing services failed to seek clarification on the 1/28/13 fax order where the PRT Modified could be used until the doctor evaluated client J on 12/29/12. Client J's 12/29/12 doctor's progress note indicated the facility's nurse did not seek clarification and/or have client J's doctor document if staff should be restraining client J with a PRT restraint and/or Modified PRT restraint technique since his evaluation.</p> <p>Interview with Health Services Coordinator (HSC) #1, TTC #1 and QSP #2 on 1/28/13 at 12:10 PM indicated client J complained of pain in her left shoulder. HSC #1 indicated the doctor evaluated client J on 12/29/12. HSC #1 indicated no additional clarification was obtained for client J in regard to the PRT usage.</p> <p>This federal tag relates to complaints #IN00122083 and #IN00122955.</p> | | | |

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

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FORM APPROVED

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