

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G673	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/15/2016
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3521 OXFORD SOUTH BEND, IN 46615
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W 0000 Bldg. 00	<p>This visit was for the investigation of Complaint #IN00195277.</p> <p>COMPLAINT #IN00195277 - SUBSTANTIATED, Federal/State deficiencies related to the allegation are cited at W102, W104, W122, W149, and W214.</p> <p>Dates of Survey: March 14 and 15, 2016.</p> <p>Facility number: 009114 Provider number: 15G673 AIM number: 100244780</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/16/16.</p>	W 0000		
W 0102 Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, record review, and interview, the Condition of Participation</p>	W 0102	Client B had an elopement plan in place prior to moving into the	04/14/2016

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>of Governing Body is not met as the facility's governing body failed to exercise general operating direction over the facility by failing to ensure the facility had implemented an effective program to address elopement behaviors of 1 of 1 sampled client with a history of elopement behaviors (client B).</p> <p>Findings include:</p> <ol style="list-style-type: none"> Please refer to W104 as the governing body failed to develop and ensure an effective program was developed and implemented to address elopement behaviors of 1 of 1 sampled client (client B) who eloped from the facility. Please refer to W122 the Condition of Participation, Client Protections, as the governing body neglected to protect 1 of 1 sampled client with elopement behaviors (client B) who eloped from the facility. <p>This federal tag relates to complaint #IN00195277.</p> <p>9-3-1(a)</p>		<p>home. The plan did not call for line of sight supervision. Following Client B's elopement incident on 3/6/16, Dungarvin immediately put a revised elopement plan in place which does call for line of sight supervision. All staff have been trained to implement the revised plan. In conjunction with the corrective actions for W214, W104, W122 & W149, Dunganvin's behavior consultant has met with Client B and is in the process of developing a Behavior Support Plan for him to address elopement. The Program Director/ QIDP will receive disciplinary action for failing to ensure that Client B's elopement risks were properly assessed and addressed in a risk plan or BSP within the first 30 days. The Program Director / QIDP will receive retraining by 4/14/16 on these expectations. Going forward the Area Director will review all Behavior Support Plans and High Risk Plans to provide oversight and ensure that the needs of the client are addressed prior to a transition. The Area Director will also meet with the Program Director / QIDP within the first 30 days to ensure that assessment of the client's behaviors is occurring and any needs are being addressed. System wide, all Program Director / QIDPs and Area Directors will review this expectation and will ensure</p>		

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W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review, and interview, the facility's governing body failed to ensure an effective program was developed and implemented to address elopement behaviors of 1 of 1 sampled client (client B) who eloped from the facility.</p> <p>Findings include:</p> <p>Client B was observed at the group home during the 3/14/16 observation period from 4:52 A.M. until 7:00 A.M. Upon entering the group home, client B was sleeping in his bedroom. The bedroom door was ajar and in the living room area, direct care staff #3 sat in a chair monitoring client B's whereabouts. At 6:55 A.M., client B exited his bedroom and went about his daily routine. During the observation, direct care staff #3 was continuously within eyesight of client B while the client walked around the facility.</p>	W 0104	<p>that this concern is being addressed at all Dungarvin ICF-IDs.</p> <p>Client B had an elopement plan in place prior to moving into the home. The plan did not call for line of sight supervision. Following Client B's elopement incident on 3/6/16, Dungarvin immediately put a revised elopement plan in place which does call for line of sight supervision. All staff have been trained to implement the revised plan. In conjunction with the corrective action for W214 & W149, Dungarvin's behavior consultant has met with Brandon and is in the process of developing a Behavior Support Plan for Brandon to address his behaviors, including elopement. The Program Director/ QIDP will receive disciplinary action for failing to ensure that Client B's elopement risks were properly assessed and addressed in a risk plan or BSP within the first 30 days. The Program Director / QIDP will receive retraining by 4/14/16 on these expectations. System wide, all Program Director / QIDPs have reviewed this standard and will</p>	04/14/2016

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	<p>The facility's records were reviewed on 3/14/16 at 7:02 A.M. A review of facility investigations and incident reports from 1/1/16 to 3/14/16 indicated the following:</p> <p>- "Incident Type: Elopement - Evasion of required supervision as described in ISP (Individual Support Plan) as necessary for health and welfare, Date: 03/6/2016, Time: 6:45 P.M., Narrative: [Client B] was admitted to the [group home] on 2/19/16 with risk plans addressing elopement, fetal alcohol syndrome and physical aggression. After he (client B) had prepared dinner on 3/6/16, [client B] went outside to smoke. Staff members (direct care staff) continued monitoring him (client B) throughout this time, but when staff had to attend to a housemate who was having a behavior, [client B] eloped. When [client B] could not immediately be located, staff members called 911 and continued searching for [client B]. A police report was made and a detective was assigned to the case. At this time, [client B] has not been located. [Client B] is familiar with the bus system and has ridden public transportation regularly in the past. He has his ID (identification) and cell phone but does not have any money. Multiple attempts have been made to reach [client B] by phone and social media but he does not answer or respond to messages. [Client</p>		ensure that this concern is being addressed at allDungarvin ICF-IDs.				

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	<p>B] had shown a text message to a friend saying she (friend) was only '3 minutes away' to a housemate prior to eloping however the identity of the friend is not known and staff were not made aware of the message until after [client B] was gone. [Name of Facility] staff have been searching for [client B] since the time of his elopement without success and [name of facility] and his team (direct care staff and inter-disciplinary team) are continuing to work with the police to locate him. Plan to Resolve: Upon [client B's] return immediate line of sight supervision requirements and 5 minute bed checks will be put in place. The home (group home) is equipped with alarms on the windows and doors to alert staff if they are opened."</p> <p>The facility's records were further reviewed on 3/14/16 at 7:15 A.M. The review indicated the following 3/9/16 follow up to the 3/6/16 incident involving client B: "Follow-Up description: 456430 (follow-up identification number) Correction to previously reported information: [Client B] moved in to (sic) the [group home] on 1/25/16. [Client B] has not returned home at this time. [Client B] did call his sister yesterday {3/8/16} and texted his father last night. He (client B) will not disclose his location</p>			

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	<p>but has stated that he is all right (sic) and is with friends and does not want to live in a group home. At this point it is not possible to verify that [client B] is not injured but it is not suspected that he is based on his conversations with his family. It is not possible to determine [client B's] location at this time as police do not plan to track his phone. Staff have been suspended as [client B] has a history of elopement and an elopement plan in place yet [client B] was able to successfully elope. An investigation is ongoing to determine if staff were following the plan at the time of [client B's] elopement on Sunday evening (3/6/16). [Name of facility] has organized search parties to attempt to locate [client B] without success. Missing person fliers have been printed and distributed to local businesses and organizations. [Name of facility] is working with the police to attempt to locate [client B], however the police are not willing to track his phone or issue a Silver Alert (community alert of a missing person) as [client B] is an emancipated adult and left of his own free will. [Name of facility] has expressed concern to the police over this decision as [client B] is an disabled adult who requires a supervised living arrangement, however the police department maintains they will not track</p>			

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	<p>his phone or issue a Silver Alert. [Name of facility] has contacted APS (Adult Protective Services) for assistance in working with the police to locate [client B], however the instigator (sic) stated that she is unable to open a case as [client B's] whereabouts are unknown and it is a police matter. [Name of facility] will continue to search for [client B] until he has been located and the police and/or APS determine that he is safe. [Name of Facility] has provided leads to the police based on friends that [client B] may be with, however none of the leads have been successful. [Name of facility] will continue to work with the police to attempt to locate [client B]. Follow-Up Systemic Actions: 456030 In the event that [client B] does return to the group home, immediate line of sight supervision requirement and 5 minute bed checks will be put in place. The home is equipped with alarms on the windows and doors to alert staff if they are opened."</p> <p>The facility's records were further reviewed on 3/14/16 at 7:37 A.M. The review of the investigation of client B's 3/6/16 elopement indicated client B was located on 3/9/16 and returned to the group home. The review further indicated client B had a history of several elopements at a previous placement.</p>			

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	<p>Client B's record was reviewed on 3/14/16 at 7:49 A.M. The review indicated client B was admitted to the facility on 1/25/16. Review of the client's 4/8/15 Diagnostic Evaluation indicated client B had a "Hx (history) of running away and impulsive behaviors." Review of the client's 10/19/15 "FSSA (Family Social Services Administration) Level of Care assessment indicated client B had "substantial limitations in capacity for self-direction and independent living. Struggles with understanding community awareness." Review of the client's "New Admission Individual Data", (no date) indicated client B required 24 hr (hour) supervision. Review of the client's IDT (Inter-Disciplinary Team) meeting minutes, dated 1/15/16, indicated client B had "Hx of elopement - elopement plan needed - line of sight supervision." Further review of client B's record failed to indicate the client's elopement behaviors had been assessed to the attendant risks of elopement, and to determine what type and degree of interventions would be necessary, in addressing the client's elopement behaviors.</p> <p>House manager #1 was interviewed on 3/14/16 at 8:07 A.M. House manager #1 stated, "We knew he (client B) had a</p>			

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	<p>history of running away (elopement) and we had an initial plan that addressed his (client B's) running away. It just wasn't effective enough. When he (client B) came back (returned to the group home), a new plan was developed and this new plan is effective." When asked if the client's attendant risks of elopement were assessed upon admission, House manager #1 stated, "No. He (client B) sees the Behavioral Clinician today (3/14/16) to start that process."</p> <p>Client B's record was further reviewed on 3/14/16 at 8:51 A.M. Review of an "Elopement Care Plan for [Client B]", dated 1/20/16, indicated, in part, direct care staff were to do "Frequent monitoring of [client B's] whereabouts."</p> <p>Client B's record was further reviewed on 3/14/16 at 9:03 A.M. Review of the client's "Risk Plan for Elopement", dated 3/9/16, indicated, in part, "Current Status" [Client B] has an extensive history of elopement and most recently eloped on 3/6/16 and was gone for 3 days." The client's "Risk Plan for Elopement" further indicated "[Client B] will remain in line of sight supervision at all times, including waking and sleeping hours." Further review indicated all direct care staff who worked at the facility were trained on the client's 3/9/16</p>			

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W 0122 Bldg. 00	<p>"Risk Plan for Elopement" on 3/9/16.</p> <p>Area Director #1 was interviewed on 3/14/16 at 9:25 A.M. Area Director #1 stated, "Yeah, we (the facility) should have done (implemented) the line of sight risk plan (Client B's 3/9/16 Risk Plan for Elopement) in the first place."</p> <p>This federal tag relates to complaint #IN00195277.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, record review, and interview, the Condition of Participation of Client Protections is not met as the facility neglected to protect 1 of 1 sampled client with elopement behaviors (client B) from eloping from the facility.</p> <p>Findings include:</p> <p>1. Please refer to W149 as the facility neglected to implement their abuse/neglect policy to effectively address the elopement behaviors of 1 of 1</p>	W 0122	Client B had an elopement plan in place prior to moving into the home. The plan did not call for line of sight supervision. Following Client B's elopement incident on 3/6/16, Dungarvin immediately put a revised elopement plan in place which does call for line of sight supervision. All staff have been trained to implement the revised plan. In conjunction with the corrective actions for W214, W104 & W149, Dungarvin's behavior consultant has met with Client B and is in the process	04/14/2016

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W 0149 Bldg. 00	<p>sampled client (client B) who eloped from the facility.</p> <p>This federal tag relates to complaint #IN00195277.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review, and interview, the facility neglected to implement their abuse/neglect policy to effectively address the elopement</p>	W 0149	<p>of developing a Behavior Support Plan for him to address elopement. The Program Director/ QIDP will receive disciplinary action for failing to ensure that Client B's elopement risks were properly assessed and addressed in a risk plan or BSP within the first 30 days. The Program Director / QIDP will receive retraining by 4/14/16 on these expectations. Going forward the Area Director will review all Behavior Support Plans and High Risk Plans to provide oversight and ensure that the needs of the client are addressed prior to a transition. The Area Director will also meet with the Program Director / QIDP within the first 30 days to ensure that assessment of the client's behaviors is occurring and any needs are being addressed. System wide, all Program Director / QIDPs and Area Directors will review this expectation and will ensure that this concern is being addressed at all Dungarvin ICF-IDs.</p> <p>All staff are trained upon hire, annually and on an as-needed basis on the policy and procedure concerning abuse, neglect, and exploitation. The Program</p>	04/14/2016

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	<p>behaviors of 1 of 1 sampled client (client B) who eloped from the facility.</p> <p>Findings include:</p> <p>Client B was observed at the group home during the 3/14/16 observation period from 4:52 A.M. until 7:00 A.M. Upon entering the group home, client B was sleeping in his bedroom. The bedroom door was ajar and in the living room area, direct care staff #3 sat in a chair monitoring client B's whereabouts. At 6:55 A.M., client B exited his bedroom and went about his daily routine. During the observation, direct care staff #3 was continuously within eyesight of client B while the client walked around the facility.</p> <p>The facility's records were reviewed on 3/14/16 at 7:02 A.M. A review of facility investigations and incident reports from 1/1/16 to 3/14/16 indicated the following:</p> <p>- "Incident Type: Elopement - Evasion of required supervision as described in ISP (Individual Support Plan) as necessary for health and welfare, Date: 03/6/2016, Time: 6:45 P.M., Narrative: [Client B] was admitted to the [group home] on 2/19/16 with risk plans addressing elopement, fetal alcohol syndrome and physical aggression. After he (client B)</p>		<p>Director/QIDP and all direct care staff at the home will be retrained on abuse, neglect and exploitation policy by 4/14/16. All staff have been trained on Client B's revised risk plan for elopement which requires line of sight supervision.</p> <p>In conjunction with the corrective action for W214, Dungarvin's behavior consultant has met with Brandon and is in the process of developing a Behavior Support Plan for Brandon to address his behaviors, including elopement.</p> <p>For the next six weeks, the Program Director/QIDP will conduct five weekly unannounced visits to the home on various shifts in order to ensure that staff are accurately implementing Client B's elopement risk plan. During the observations, the Program Director/QIDP will offer immediate feedback to the staff members in an effort to coach the staff that are not implementing the risk plan appropriately to ensure the staff understand what needs to be done to complete the expectations and to ensure the safety of Client B. The visits will be documented on a site visit observation form and the Area Director will review them on a weekly basis for quality assurance purposes. After six weeks the visits will taper off when proficiency has been determined. System wide, all Program Director/QIDP's will review this standard and assure that this</p>		

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	had prepared dinner on 3/6/16, [client B] went outside to smoke. Staff members (direct care staff) continued monitoring him (client B) throughout this time, but when staff had to attend to a housemate who was having a behavior, [client B] eloped. When [client B] could not immediately be located, staff members called 911 and continued searching for [client B]. A police report was made and a detective was assigned to the case. At this time, [client B] has not been located. [Client B] is familiar with the bus system and has ridden public transportation regularly in the past. He has his ID (identification) and cell phone but does not have any money. Multiple attempts have been made to reach [client B] by phone and social media but he does not answer or respond to messages. [Client B] had shown a text message to a friend saying she (friend) was only '3 minutes away' to a housemate prior to eloping however the identity of the friend is not known and staff were not made aware of the message until after [client B] was gone. [Name of Facility] staff have been searching for [client B] since the time of his elopement without success and [name of facility] and his team (direct care staff and inter-disciplinary team) are continuing to work with the police to locate him. Plan to Resolve: Upon [client B's] return immediate line of sight		concernis being addressed at all Dunganrvin ICF-ID's.		

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	<p>supervision requirements and 5 minute bed checks will be put in place. The home (group home) is equipped with alarms on the windows and doors to alert staff if they are opened."</p> <p>The facility's records were further reviewed on 3/14/16 at 7:15 A.M. The review indicated the following 3/9/16 follow up to the 3/6/16 incident involving client B: "Follow-Up description: 456430 (follow-up identification number) Correction to previously reported information: [Client B] moved in to (sic) the [group home] on 1/25/16. [Client B] has not returned home at this time. [Client B] did call his sister yesterday {3/8/16} and texted his father last night. He (client B) will not disclose his location but has stated that he is all right (sic) and is with friends and does not want to live in a group home. At this point it is not possible to verify that [client B] is not injured but it is not suspected that he is based on his conversations with his family. It is not possible to determine [client B's] location at this time as police do not plan to track his phone. Staff have been suspended as [client B] has a history of elopement and an elopement plan in place yet [client B] was able to successfully elope. An investigation is ongoing to determine if staff were</p>			

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	<p>following the plan at the time of [client B's] elopement on Sunday evening (3/6/16). [Name of facility] has organized search parties to attempt to locate [client B] without success. Missing person fliers have been printed and distributed to local businesses and organizations. [Name of facility] is working with the police to attempt to locate [client B], however the police are not willing to track his phone or issue a Silver Alert (community alert of a missing person) as [client B] is an emancipated adult and left of his own free will. [Name of facility] has expressed concern to the police over this decision as [client B] is an disabled adult who requires a supervised living arrangement, however the police department maintains they will not track his phone or issue a Silver Alert. [Name of facility] has contacted APS (Adult Protective Services) for assistance in working with the police to locate [client B], however the instigator (sic) stated that she is unable to open a case as [client B's] whereabouts are unknown and it is a police matter. [Name of facility] will continue to search for [client B] until he has been located and the police and/or APS determine that he is safe. [Name of Facility] has provided leads to the police based on friends that [client B] may be with, however none of the leads have</p>			

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	<p>been successful. [Name of facility] will continue to work with the police to attempt to locate [client B]. Follow-Up Systemic Actions: 456030 In the event that [client B] does return to the group home, immediate line of sight supervision requirement and 5 minute bed checks will be put in place. The home is equipped with alarms on the windows and doors to alert staff if they are opened."</p> <p>The facility's records were further reviewed on 3/14/16 at 7:37 A.M. The review of the investigation of client B's 3/6/16 elopement indicated client B was located on 3/9/16 and returned to the group home. The review further indicated client B had a history of several elopements at a previous placement.</p> <p>Client B's record was reviewed on 3/14/16 at 7:49 A.M. The review indicated client B was admitted to the facility on 1/25/16. Review of the client's 4/8/15 Diagnostic Evaluation indicated client B had a "Hx (history) of running away and impulsive behaviors." Review of the client's 10/19/15 "FSSA (Family Social Services Administration) Level of Care assessment indicated client B had "substantial limitations in capacity for self-direction and independent living. Struggles with understanding community</p>				

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	<p>awareness." Review of the client's "New Admission Individual Data", (no date) indicated client B required 24 hr (hour) supervision. Review of the client's IDT (Inter-Disciplinary Team) meeting minutes, dated 1/15/16, indicated client B had "Hx of elopement - elopement plan needed - line of sight supervision." Further review of client B's record failed to indicate the client's elopement behaviors had been assessed to the attendant risks of elopement, and to determine what type and degree of interventions would be necessary, in addressing the client's elopement behaviors.</p> <p>House manager #1 was interviewed on 3/14/16 at 8:07 A.M. House manager #1 stated, "We knew he (client B) had a history of running away (elopement) and we had an initial plan that addressed his (client B's) running away. It just wasn't effective enough. When he (client B) came back (returned to the group home), a new plan was developed and this new plan is effective." When asked if the client's attendant risks of elopement were assessed upon admission, House manager #1 stated, "No. He (client B) sees the Behavioral Clinician today (3/14/16) to start that process."</p> <p>Client B's record was further reviewed on</p>			

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	<p>3/14/16 at 8:51 A.M. Review of an "Elopement Care Plan for [Client B]", dated 1/20/16, indicated, in part, direct care staff were to do "Frequent monitoring of [client B's] whereabouts."</p> <p>Client B's record was further reviewed on 3/14/16 at 9:03 A.M. Review of the client's "Risk Plan for Elopement", dated 3/9/16, indicated, in part, "Current Status" [Client B] has an extensive history of elopement and most recently eloped on 3/6/16 and was gone for 3 days." The client's "Risk Plan for Elopement" further indicated "[Client B] will remain in line of sight supervision at all times, including waking and sleeping hours." Further review indicated all direct care staff who worked at the facility were trained on the client's 3/9/16 "Risk Plan for Elopement" on 3/9/16.</p> <p>Area Director #1 was interviewed on 3/14/16 at 9:25 A.M. Area Director #1 stated, "Yeah, we (the facility) should have done (implemented) the line of sight risk plan (Client B's 3/9/16 Risk Plan for Elopement) in the first place."</p> <p>The facility's records were further reviewed on 3/15/16 at 10:04 A.M. A review of the facility's "Policy and Procedure Concerning Abuse, Neglect and Exploitation", dated 6/1/15,</p>				

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W 0214 Bldg. 00	<p>indicated, in part, "C. Neglect is defined as failure to provide appropriate care, supervision or training . . ."</p> <p>This federal tag relates to complaint #IN00195277.</p> <p>9-3-2(a)</p> <p>483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.</p> <p>Based on record review and interview, the facility failed to assess the attendant risks of elopement behaviors for 1 of 1 client (client B) who had a documented history of elopement.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 3/14/16 at 7:02 A.M. A review of facility investigations and incident reports from 1/1/16 to 3/14/16 indicated the following:</p> <p>- "Incident Type: Elopement - Evasion of required supervision as described in ISP (Individual Support Plan) as necessary for health and welfare, Date: 03/6/2016,</p>	W 0214	<p>Client B had an elopement plan in place prior to moving into the home. The plan did not call for line of sight supervision.</p> <p>Following Client B's elopement incident on 3/6/16, Dungarvin immediately put a revised elopement plan in place which does call for line of sight supervision. Allstaff have been trained to implement the revised plan. Dungarvin's behaviorconsultant has met with Brandon and is in the process of developing a Behavior Support Plan for Brandon to address his behaviors, including elopement. The Program Director/ QIDP will receive disciplinary action for failing to ensure Client B's behaviors, including</p>	04/14/2016			

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	Time: 6:45 P.M., Narrative: [Client B] was admitted to the [group home] on 2/19/16 with risk plans addressing elopement, fetal alcohol syndrome and physical aggression. After he (client B) had prepared dinner on 3/6/16, [client B] went outside to smoke. Staff members (direct care staff) continued monitoring him (client B) throughout this time, but when staff had to attend to a housemate who was having a behavior, [client B] eloped. When [client B] could not immediately be located, staff members called 911 and continued searching for [client B]. A police report was made and a detective was assigned to the case. At this time, [client B] has not been located. [Client B] is familiar with the bus system and has ridden public transportation regularly in the past. He has his ID (identification) and cell phone but does not have any money. Multiple attempts have been made to reach [client B] by phone and social media but he does not answer or respond to messages. [Client B] had shown a text message to a friend saying she (friend) was only '3 minutes away' to a housemate prior to eloping however the identity of the friend is not known and staff were not made aware of the message until after [client B] was gone. [Name of Facility] staff have been searching for [client B] since the time of his elopement without success and [name		his elopement risks, were assessed within the first 30 days of his placement in the home. The Program Director / QIDP will be re-trained by 4/14/16 on the expectation that all behaviors will be assessed within the first 30 days. System wide, all Program Director / QIDPs have reviewed this standard and will ensure that this concern is being addressed at all Dungarvin ICF-IDs.	

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	<p>of facility] and his team (direct care staff and inter-disciplinary team) are continuing to work with the police to locate him. Plan to Resolve: Upon [client B's] return immediate line of sight supervision requirements and 5 minute bed checks will be put in place. The home (group home) is equipped with alarms on the windows and doors to alert staff if they are opened."</p> <p>The facility's records were further reviewed on 3/14/16 at 7:15 A.M. The review indicated the following 3/9/16 follow up to the 3/6/16 incident involving client B: "Follow-Up description: 456430 (follow-up identification number) Correction to previously reported information: [Client B] moved in to (sic) the [group home] on 1/25/16. [Client B] has not returned home at this time. [Client B] did call his sister yesterday {3/8/16} and texted his father last night. He (client B) will not disclose his location but has stated that he is all right (sic) and is with friends and does not want to live in a group home. At this point it is not possible to verify that [client B] is not injured but it is not suspected that he is based on his conversations with his family. It is not possible to determine [client B's] location at this time as police do not plan to track his phone. Staff have</p>			

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	<p>been suspended as [client B] has a history of elopement and an elopement plan in place yet [client B] was able to successfully elope. An investigation is ongoing to determine if staff were following the plan at the time of [client B's] elopement on Sunday evening (3/6/16). [Name of facility] has organized search parties to attempt to locate [client B] without success. Missing person fliers have been printed and distributed to local businesses and organizations. [Name of facility] is working with the police to attempt to locate [client B], however the police are not willing to track his phone or issue a Silver Alert (community alert of a missing person) as [client B] is an emancipated adult and left of his own free will. [Name of facility] has expressed concern to the police over this decision as [client B] is an disabled adult who requires a supervised living arrangement, however the police department maintains they will not track his phone or issue a Silver Alert. [Name of facility] has contacted APS (Adult Protective Services) for assistance in working with the police to locate [client B], however the instigator (sic) stated that she is unable to open a case as [client B's] whereabouts are unknown and it is a police matter. [Name of facility] will continue to search for [client B] until he</p>			

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	<p>has been located and the police and/or APS determine that he is safe. [Name of Facility] has provided leads to the police based on friends that [client B] may be with, however none of the leads have been successful. [Name of facility] will continue to work with the police to attempt to locate [client B]. Follow-Up Systemic Actions: 456030 In the event that [client B] does return to the group home, immediate line of sight supervision requirement and 5 minute bed checks will be put in place. The home is equipped with alarms on the windows and doors to alert staff if they are opened."</p> <p>The facility's records were further reviewed on 3/14/16 at 7:37 A.M. The review of the investigation of client B's 3/6/16 elopement indicated client B was located on 3/9/16 and returned to the group home. The review further indicated client B had a history of several elopements at a previous placement.</p> <p>Client B's record was reviewed on 3/14/16 at 7:49 A.M. The review indicated client B was admitted to the facility on 1/25/16. Review of the client's 4/8/15 Diagnostic Evaluation indicated client B had a "Hx (history) of running away and impulsive behaviors." Review of the client's 10/19/15 "FSSA (Family</p>			

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	<p>Social Services Administration) Level of Care assessment indicated client B had "substantial limitations in capacity for self-direction and independent living. Struggles with understanding community awareness." Review of the client's "New Admission Individual Data", (no date) indicated client B required 24 hr (hour) supervision. Review of the client's IDT (Inter-Disciplinary Team) meeting minutes, dated 1/15/16, indicated client B had "Hx of elopement - elopement plan needed - line of sight supervision." Further review of client B's record failed to indicated the client's elopement behaviors had been assessed to the attendant risks of elopement, and to determine what type and degree of interventions would be necessary, in addressing the client's elopement behaviors.</p> <p>House manager #1 was interviewed on 3/14/16 at 8:07 A.M. House manager #1 stated, "We knew he (client B) had a history of running away (elopement) and we had an initial plan that addressed his (client B's) running away. It just wasn't effective enough. When he (client B) came back (returned to the group home), a new plan was developed and this new plan is effective." When asked if the client's attendant risks of elopement were assessed upon admission, House manager</p>			

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	<p>#1 stated, "No. He (client B) sees the Behavioral Clinician today (3/14/16) to start that process."</p> <p>This federal tag relates to complaint #IN00195277.</p> <p>9-3-4(a)</p>						