

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2014
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NAME OF PROVIDER OR SUPPLIER VOCA CORPORATION OF INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 2900 KENTUCKY AVE MADISON, IN 47250
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W000000	<p>This visit was for the investigation of complaint #IN00147210. This visit resulted in an Immediate Jeopardy.</p> <p>Complaint #IN00147210 - Substantiated. Federal and state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W156, W186 and W407.</p> <p>Survey Dates: April 21, 22, 23, 24 and 25, 2014.</p> <p>Facility Number: 001021 Provider Number: 15G507 AIMS Number: 100245130</p> <p>Survey Team: Jo Anna Scott, QIDP-TC. Dotty Walton, QIDP (4/25/14).</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/2/14 by Ruth Shackelford, QIDP.</p>	W000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, record review and interview, the facility's governing body failed to meet the Condition of Participation: Governing Body for 4 of 4 sampled clients (clients A, B, C and D) and 4 additional clients (clients E, F, G and H). The governing body failed to exercise operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent potential abuse and neglect of clients in regard to client A's verbal/physical aggression and threats/intimidation of his peers and client A's elopement.</p> <p>Findings include:</p> <p>1. The facility's governing body failed to meet the Condition of Participation: Client Protections. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented written policy and procedure to ensure the rights</p>	W000102	<p>W102: The facility must ensure that specific governing body and management requirements are met. Corrective Action: (Specific): The IDT met to review the Behavior Support Plan for Client A, discussed the elopement concerns and determined that a one to one defined as within 5 feet and positioned between Client A and all others clients in the home during waking hours would be added to Client A's BSP. Staffing ratios on night shift were increased so there would always be two staff working to ensure the health and safety of Client A as well as all other clients in the home. IDT's were held with all other clients in the home to review the Bill of Rights, Grievance Policy and Procedure and measures that were put in place in regards to Client A. The local BDDS office was contacted in regards to Client A's placement and citations and a request was made for an immediate search for alternate placement. Client A was moved to a setting commensurate with his needs on 4/25/14.</p>	05/25/2014

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	<p>of all clients (A, B, C, D, E, F, G and H) to be free of abuse/neglect by failing to prevent neglect of client A in regard to elopement and failed to prevent potential abuse and neglect of clients in regard to client A's verbal/physical aggression and threats/intimidation of his peers. Please see W122.</p> <p>2. The governing body failed to exercise operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent potential abuse and neglect (A). The governing body failed to supply sufficient staff to protect clients from abuse/neglect (B, C, D, E, F, G and H). The facility's governing body failed to ensure client A was placed in a setting commensurate with his needs. Please see W104.</p> <p>This federal tag relates to complaint #IN00147210.</p> <p>9-3-1(a)</p>		<p>How others will be identified: (Systemic): All client Behavior Support Plans were reviewed to ensure that all preventative and reactive strategies were included to address all target behaviors to ensure that all clients were protected from abuse/neglect in regard to target behaviors of peers. The Residential Manager and the Program Manager will review behavior data for all clients at least monthly to ensure that all plans are effective and clients are free from the potential of abuse/neglect when it relates to target behaviors of peers. All client Behavior Support Plans will be reviewed at least quarterly by the Behavior Review Committee (BRC) to ensure that all plans remain effective.</p> <p>Measures to be put in place: The IDT met to review the Behavior Support Plan for Client A, discussed the elopement concerns and determined that a one to one defined as within 5 feet and positioned between Client A and all other clients in the home during waking hours would be added to Client A's BSP. Staffing ratios on night shift were increased so there would always be two staff working to ensure the health and safety of Client A as well as all other clients in the home. IDT's were held with all other clients in the home to review the Bill of Rights, Grievance Policy and Procedure and measures that were put in place in regards to Client</p>		

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W000104	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 for 4 of 4 sampled clients	W000104	A. The local BDDS office was contacted in regards to Client A's placement and citations and a request was made for an immediate search for alternate placement. Client A was moved to a setting commensurate with his needs on 4/25/14. Monitoring of Corrective Action: All client Behavior Support Plans were reviewed to ensure that all preventative and reactive strategies were included to address all target behaviors to ensure that all clients were protected from abuse/neglect in regard to target behaviors of peers. The Residential Manager and the Program Manager will review behavior data for all clients at least monthly to ensure that all plans are effective and clients are free from the potential of abuse/neglect when it relates to target behaviors of peers. All client Behavior Support Plans will be reviewed at least quarterly by the Behavior Review Committee (BRC) to ensure that all plans remain effective. Completion date: 05/25/14 W104: The governing body must exercise general policy, budget, and operating direction over the	05/25/2014	

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	<p>(clients A, B, C and D) and 4 additional clients (clients E, F, G and H), the governing body failed to exercise operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent potential abuse and neglect, failed to provide sufficient staff to accommodate client A's needs and failed to ensure client A was placed in a setting commensurate with his needs.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The facility's governing body failed to implement written policy and procedure to prevent potential abuse of clients B, C, D, E, F, G and H in regard to client A's physical aggression, verbal threats and intimidation. Please see W149. 2. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented written policy and procedure to prevent neglect of client A in regard to his elopements and by not providing sufficient staff on overnight shift. Please see W186. 3. The facility's governing body failed for 1 of 4 sampled clients (client A), to ensure the client was properly placed in regard to social, behavioral and 		<p>facility. Corrective Action: (Specific): The IDT met to review the Behavior Support Plan for Client A, discussed the elopement concerns and determined that a one to one defined as within 5 feet and positioned between Client A and all others clients in the home during waking hours would be added to Client A's BSP. Staffing ratios on night shift were increased so there would always be two staff working to ensure the health and safety of Client A as well as all other clients in the home. IDT's were held with all other clients in the home to review the Bill of Rights, Grievance Policy and Procedure and measures that were put in place in regards to Client A. The local BDDS office was contacted in regards to Client A's placement and citations and a request was made for an immediate search for alternate placement. Client A was moved to a setting commensurate with his needs on 4/25/14. How others will be identified: (Systemic): All client Behavior Support Plans were reviewed to ensure that all preventative and reactive strategies were included to address all target behaviors to ensure that all clients were protected from abuse/neglect in regard to target behaviors of peers. The Residential Manager and the Program Manager will review behavior data for all clients</p>		

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	<p>psychiatric needs. Please see W407.</p> <p>This federal tag relates to complaint #IN00147210.</p> <p>9-3-1(a)</p>		<p>at least monthly to ensure that all plans are effective and clients are free from the potential of abuse/neglect when it relates to target behaviors of peers. All client Behavior Support Plans will be reviewed at least quarterly by the Behavior Review Committee (BRC) to ensure that all plans remain effective. Measures to be put in place: The IDT met to review the Behavior Support Plan for Client A, discussed the elopement concerns and determined that a one to one defined as within 5 feet and positioned between Client A and all others clients in the home during waking hours would be added to Client A's BSP. Staffing ratios on night shift were increased so there would always be two staff working to ensure the health and safety of Client A as well as all other clients in the home. IDT's were held with all other clients in the home to review the Bill of Rights, Grievance Policy and Procedure and measures that were put in place in regards to Client A. The local BDDS office was contacted in regards to Client A's placement and citations and a request was made for an immediate search for alternate placement. Client A was moved to a setting commensurate with his needs on 4/25/14. Monitoring of Corrective Action: All client Behavior Support Plans were reviewed to ensure that all</p>		

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W000122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 4 of 4 sampled clients (clients A, B, C and D) and 4 additional clients (clients E, F, G and H). The facility failed to ensure the rights of all clients to be free of neglect, verbal, emotional and physical abuse by failing to address client A's elopements, physical and verbal aggression/intimidation. The facility failed to implement written policy and procedures to prevent neglect of client A in regards to client A leaving the	W000122	preventative and reactive strategies were included to address all target behaviors to ensure that all clients were protected from abuse/neglect in regard to target behaviors of peers. The Residential Manager and the Program Manager will review behavior data for all clients at least monthly to ensure that all plans are effective and clients are free from the potential of abuse/neglect when it relates to target behaviors of peers. All client Behavior Support Plans will be reviewed at least quarterly by the Behavior Review Committee (BRC) to ensure that all plans remain effective. Completion date: 05/25/14 W122: The facility must ensure that specific client protections requirements are met. Corrective Action: (Specific): The IDT met to review the Behavior Support Plan for Client A, discussed the elopement concerns and determined that a one to one defined as within 5 feet and positioned between Client A and all others clients in the home during waking hours would be added to Client A's BSP. Staffing ratios on night shift were increased so there would always be two staff working to ensure the health and safety of Client A as well as all other clients in the	05/25/2014	

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	<p>group home and/or preventing abuse/neglect of clients B, C, D, E, F, G and H during client A's episodes of verbal and physical aggression and threatening/intimidation behaviors.</p> <p>This noncompliance resulted in an Immediate Jeopardy. The Immediate Jeopardy was identified on 4/23/14 at 3:46 PM. The Immediate Jeopardy began on 12/13/13 when the facility failed to protect client C from being pushed down by client A during a behavioral episode resulting in injury to client C. The facility failed to provide staff with sufficient support when client A left the group home. The facility failed to protect clients B, C, D, E, F, G, and H from verbal and physical aggression and threatening/intimidation behaviors from client A. The Residential Manager was notified of the Immediate Jeopardy on 4/23/14 at 4:00 PM regarding the failure of the facility's system to identify and/or prevent neglect/abuse of clients A, B, C, D, E, F, G and H in the facility.</p>		<p>home. IDT's were held with all other clients in the home to review the Bill of Rights, Grievance Policy and Procedure and measures that were put in place in regards to Client A. The local BDDS office was contacted in regards to Client A's placement and citations and a request was made for an immediate search for alternate placement. Client A was moved to a setting commensurate with his needs on 4/25/14.</p> <p>How others will be identified: (Systemic): All client Behavior Support Plans were reviewed to ensure that all preventative and reactive strategies were included to address all target behaviors to ensure that all clients were protected from abuse/neglect in regard to target behaviors of peers. The Residential Manager and the Program Manager will review behavior data for all clients at least monthly to ensure that all plans are effective and clients are free from the potential of abuse/neglect when it relates to target behaviors of peers. All client Behavior Support Plans will be reviewed at least quarterly by the Behavior Review Committee (BRC) to ensure that all plans remain effective.</p> <p>Measures to be put in place: The IDT met to review the Behavior Support Plan for Client A, discussed the elopement concerns and determined that a one to one defined as within 5 feet and positioned</p>		

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			<p>between Client A and all others clients in the home during waking hours would be added to Client A's BSP. Staffing ratios on night shift were increased so there would always be two staff working to ensure the health and safety of Client A as well as all other clients in the home. IDT's were held with all other clients in the home to review the Bill of Rights, Grievance Policy and Procedure and measures that were put in place in regards to Client A. The local BDDS office was contacted in regards to Client A's placement and citations and a request was made for an immediate search for alternate placement. Client A was moved to a setting commensurate with his needs on 4/25/14.</p> <p>Monitoring of Corrective Action: All client Behavior Support Plans were reviewed to ensure that all preventative and reactive strategies were included to address all target behaviors to ensure that all clients were protected from abuse/neglect in regard to target behaviors of peers. The Residential Manager and the Program Manager will review behavior data for all clients at least monthly to ensure that all plans are effective and clients are free from the potential of abuse/neglect when it relates to target behaviors of peers. All client Behavior Support Plans will be reviewed at least quarterly by the Behavior Review Committee (BRC) to ensure that all plans remain</p>	

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 1 of 4 sampled clients (client A), the facility neglected to implement written policy and procedures to prevent neglect of client A in regards to the client leaving the group home. Based on observation, record review and interview for 3 of 4 sampled clients (clients B, C and D) and 4 additional clients (clients E, F, G and H), the facility neglected to implement written policy and procedures to prevent abuse/neglect of clients in regards to client A's verbal and physical aggression and threatening/intimidation behaviors towards clients B, C, D, E, F, G and H.</p> <p>Findings include:</p> <p>The facility's reportable incidents and injury reports were reviewed on 4/21/14 at 3:00 PM regarding Client A's behavioral incidents as follows:</p> <p>12/13/13 at 4:55 AM - "[Client A] and [client C] were both heading to the</p>	W000149	<p>effective.</p> <p>Completion date: 05/25/14</p> <p>W149: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Corrective Action: (Specific): The IDT met to review the Behavior Support Plan for Client A, discussed the elopement concerns and determined that a one to one defined as within 5 feet and positioned between Client A and all others clients in the home during waking hours would be added to Client A's BSP. Staffing ratios on night shift were increased so there would always be two staff working to ensure the health and safety of Client A as well as all other clients in the home. IDT's were held with all other clients in the home to review the Bill of Rights, Grievance Policy and Procedure and measures that were put in place in regards to Client A. The local BDDS office was contacted in regards to Client A's placement and citations and a request was made for an immediate search for alternate placement. Client A was moved to a setting commensurate with his needs on</p>	05/25/2014

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	<p>bathroom at 4:55 AM and ran into each other. [Client C] fell face down on the floor, while [client A] continued on to the bathroom and took a shower. [Client C's] nose was bleeding and 911 was called so [client C] could be evaluated at the Emergency Room (ER)."</p> <p>1/2/14 at 8:40 AM - "Staff were getting individuals ready to go to grocery store. [Client A] got upset and hit and pushed staff. Redirection techniques were used and it was decided to take him to ER via EMS (Emergency Service) for an evaluation. Once at the ER, [client A] was assessed by the psychiatrist and given 15 mg (milligrams) of Zyprexa, diagnosed with schizophrenic exacerbation and orders to have a psych evaluation in the next 3 - 5 days and discharged back to the group home, and was calm. The Director of Health Services contacted [client A's] psychiatrist and he ordered to hold [client A's] Prozac until further notice and increase his Seroquel to 200 mg in AM and noon and 400 mg at bedtime. HRC (Human Rights Committee) and guardian were notified and approved of the medication changes."</p> <p>2/20/14 at 6:30 AM - "[Client A] was agitated and became verbally aggressive, which escalated into physical aggression</p>		<p>4/25/14.</p> <p>How others will be identified: (Systemic): All client Behavior Support Plans were reviewed to ensure that all preventative and reactive strategies were included to address all target behaviors to ensure that all clients were protected from abuse/neglect in regard to target behaviors of peers. The Residential Manager and the Program Manager will review behavior data for all clients at least monthly to ensure that all plans are effective and clients are free from the potential of abuse/neglect when it relates to target behaviors of peers. All client Behavior Support Plans will be reviewed at least quarterly by the Behavior Review Committee (BRC) to ensure that all plans remain effective.</p> <p>Measures to be put in place: The IDT met to review the Behavior Support Plan for Client A, discussed the elopement concerns and determined that a one to one defined as within 5 feet and positioned between Client A and all others clients in the home during waking hours would be added to Client A's BSP. Staffing ratios on night shift were increased so there would always be two staff working to ensure the health and safety of Client A as well as all other clients in the home. IDT's were held with all other clients in the home to review the Bill of Rights, Grievance Policy and Procedure and measures that</p>	

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	towards staff. The police and EMS (Emergency Services) were called to assist in de-escalating the behavior for everyone's safety. After the police arrived at the home [client A] calmed down and went to his room. No charges were filed and the police left the home. A few hours later [client A] came out of his room and told staff he was leaving, exited the home and started walking down the road. Staff immediately followed him on foot and another staff followed behind in the van and attempted to re-direct him to the home. Staff were finally able to verbally redirect [client A] and he got in the van with staff. Due to his continued agitation and verbal threats the team felt it was warranted that he be transported to the ER (Emergency Room) for an evaluation for inpatient psychiatric evaluation and treatment. [Client A] sustained no injury as a result of the incident. [Client A] was transported to the ER and was evaluated by the physician and the social worker, he was given 2 mg (milligram) IM (injection) of Zyprexa 25 mg IM at the ER and the ER made contact with several inpatient behavioral health units for admission and inpatient placement could not be secured. The hospital kept [client A] in the ER overnight and continued evaluation. His agitation continued off and on throughout the night and the ER physician ordered an		were put in place in regards to Client A. The local BDDS office was contacted in regards to Client A's placement and citations and a request was made for an immediate search for alternate placement. Client A was moved to a setting commensurate with his needs on 4/25/14. Monitoring of Corrective Action: All client Behavior Support Plans were reviewed to ensure that all preventative and reactive strategies were included to address all target behaviors to ensure that all clients were protected from abuse/neglect in regard to target behaviors of peers. The Residential Manager and the Program Manager will review behavior data for all clients at least monthly to ensure that all plans are effective and clients are free from the potential of abuse/neglect when it relates to target behaviors of peers. All client Behavior Support Plans will be reviewed at least quarterly by the Behavior Review Committee (BRC) to ensure that all plans remain effective. Completion date: 05/25/14	

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	<p>injection of Haldol this morning to decrease [client A's] agitation. Shortly after the Haldol was administered [client A's] agitation subsided and he told the hospital staff and the group home nurse that he wanted to go back to the group home. [Client A] was discharged back to the group home with orders to continue current psychotropic medications and follow up with his psychiatrist. He is back home resting comfortably, has had no further signs of agitation and has had appropriate interaction with staff and house mates. His psychiatrist was contacted after discharge and new orders were received for Haldol 5 mg po (by mouth) TID (three times a day) and to decrease Zyprexa to from 15 mg BID (two times a day) to 15 mg at HS (bed time) for diagnoses of Personality Disorder and Impulse Control Disorder. The team has met to discuss the incident and review current BSP (Behavior Support Plan). The team feels that the BSP and all reactive and preventative strategies remain appropriate but felt that leaving assigned area should be added with specific preventative and reactive strategies to address. The guardian was aware of the incident, involved in all decisions regarding [client A's] care and has approved the medication changes as well as the revisions of the BSP. In addition, the revised BSP is in the home</p>			

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	<p>and all staff have been trained on the revisions."</p> <p>3-3-14 at 3:10 PM - "[Client A] left the home walking toward [name of store] and the site nurse was following him and attempting re-direction back to the home. [Client A] was only wearing socks, refused to put on his shoes or return to the home. The police were contacted for assistance and once they arrived they were able to talk to [client A] and he got into the vehicle with the residential manager. He was transported to the ER for evaluation as a precautionary measure. [Client A] was assessed by the ER physician and nothing problematic was identified. The physician discharge orders read exposure to cold and to continue care with [name of facility]. The staff attempted to take [client A] back to the home and he refused to leave the hospital. [Client A] began exhibiting behaviors, began yelling, cussing and screaming. The police were called for assistance and [client A] agreed to return to the group home. As the site nurse and residential manager were walking out with [client A], [client A] and the site nurse slipped and fell on the ice. [Client A] sustained no injury as a result of the incident but the site nurse hit her head and required evaluation. Once they went back into the hospital [client A] again</p>			
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	<p>refused to leave and again started cussing and yelling, laying on the floor and hitting walls and glass. The staff asked for inpatient psychiatric evaluation and treatment. He was assessed and made threats to harm himself, the hospital attempted to find an inpatient facility for evaluation and treatment and no one would accept [client A]. [Client A] was cleared medically and released to the group home. The team met to discuss the situation and recent behavioral episodes. The team agreed to have his current LOC (Level of Care) reviewed, increase staffing in the home, request a referral to state contracted psychiatrist, review current BSP and make adjustments as indicated, complete observations at the home by the [facility's name] behavior clinician, re-train staff on BSP and consult with current treating psychiatrist regarding current medication regimen and recent behaviors related to diagnosis for possible medication adjustments and continue to monitor and track behaviors. [Client A] is back at the home and has had no further complaints of behaviors."</p> <p>The internal incident reports were reviewed on 4/21/14 at 4:30 PM. The reports for client A were as follows:</p> <p>2/20/14 at 5:20 AM - "[Client A] tried to make breakfast. [Client A]</p>			
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	<p>punched my right arm. I (staff #5) walked away and let him make breakfast."</p> <p>2/20/14 at 6:30 AM - "[Client A] had been verbally aggressive at working staff about eating more breakfast. He continued verbal aggression and escalated to physical aggression, punched working staff. Residential Manager came through the doorway and consumer immediately attacked her without warning. He forced her to the floor where he hit her head on the floor and pulled out her hair. While on the floor he attempted to bite her and kicked at her twisting her arm and hitting her back. He choked her neck with his hands before being redirected out of the area. YSIS (You're Safe I'm Safe) was attempted but was not successful. EMS (Emergency Services)/Police were called and [Client A] was verbally redirected. He returned to his bedroom and threw his gaming system 'Playstation' to the floor and smashing it. He then calmed down and returned to bed. No injury to client. Manager taken to ER."</p> <p>2/20/14 at 10:00 AM - "[Client A] came out of his room and stated to staff he was running away to [name of city]. [Client A] walked out the back door. Staff called RM (Residential Manager)</p>			

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	<p>and LPN (Licensed Practical Nurse) for assistance. [Client A] was followed closely down the road for two miles before he became tired and willingly got into the van. After entering van he escalated into physical and verbal aggression and was taken to emergency room. [Client A] was taken to ER for evaluation."</p> <p>2/23/14 at 5:00 AM - "[Client A] wanted to take his shower about 3:30 AM but there were other clients up in the bathrooms at that time. [Client A] became upset and was verbally aggressive towards staff, said he would stab her with a knife. Also threw remote at wall."</p> <p>2/28/14 at 9:45 AM - "[Client A] was sitting on the couch with his coat on at 8:00 AM. He was supposed to go to [restaurant] for lunch with LPN. Staff told him several times he had awhile to wait. At 9:30 AM he started verbally aggressive (behavior) towards (Residential Manager). I tried to redirect him and he decided he was leaving anyways. [Client A] was outside and was headed down the drive way when [LPN] showed up. She finally got him to come back. He came inside and sat on the couch and was still very verbal (verbally aggressive) towards her and (Residential</p>			

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	<p>Manager). He then got up and went to his room and laid down. He is still there at this time."</p> <p>3/3/14 at 9:15 AM - "Clients were watching TV (television). [Client A] came in the living room and wanted to change the channel and the others were watching the show. Told [client A] it went off at 10 AM then he could watch something. At this time he starts cursing me and the other staff then starts threatening [client E] and [client B] to hit them and cursing them. Got all clients to their rooms and [client A] stayed in there cursing for another 15 minutes. Now he is in his room."</p> <p>3/3/14 at 3:10 PM - "[Client A] was upset about a shot he got. [Client A] left the house on foot. [Client A] was taken to the ER."</p> <p>3/31/14 at 3:30 PM - "[Client A] was in room playing a game. Came out of his room started yelling he was not going to eat and cursing. Staff tried to calm him down. He tried to hit staff then said he was leaving. He went to the road. Staff followed. He tried to go on [name of drive]. Staff put him in YSIS. He sat down in the yard for a little while than got up and went into the house. Sat in the living room and busted the remote to</p>			
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	<p>the TV, Sitting down at this time 4:10 PM."</p> <p>During the observation period on 4/22/14 from 2:00 PM to 6:30 PM, client A was in his room from 2:00 PM to 3:50 PM. Staff indicated client A had his snack early and went to bed after his snack. Client A came to the living room at 3:50 PM. Client A walked with an unsteady gait and told staff at 4:00 PM he was too tired to get up to take his medication. Staff #4 prompted him to stand up and he went to medication room. At 4:07 PM staff #2, RM (Residential Manager) asked client A if he would like to go for a walk with her and clients E and H. He stated "No!" Client A told a staff he wanted to play 500 Rummy. Staff #2, RM, asked a staff that had come in at 4:00 PM if she would play the card game with client A. At 5:00 PM client A wanted to watch a movie and staff asked clients B, C, D and F if they wanted to watch a movie. They all agreed and client A stayed in the living room with the other clients. Dinner was served at 5:25 PM and client E made the comment that he had quit smoking 2 years ago. Client A stated, "I never smoked, it's dumb to smoke." Client E dropped his head and didn't make another comment. Clients B, C, D, E, F, G and H continued eating dinner, but did not make any more</p>			

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	<p>comments. Client A continued to talk about how he had never smoked.</p> <p>During the observation period on 4/23/14 from 8:20 AM to 10:30 AM, client A had gone back to bed and told staff he didn't want to do anything else when prompted to do another activity. Staff #3 was interviewed on 4/23/14 at 10:00 AM and indicated they (the staff) did not like to push him to do an activity because client A would escalate into a behavior.</p> <p>During the observation period on 4/23/14 from 2:00 PM to 5:30 PM, client A stayed in his room until 4:00 PM. He wanted to watch the TV in the living room, but the other clients were watching a movie. Staff #3 offered to fix his TV in his room to the station he wanted, but he told her he wanted to watch the TV in the living room. Staff #2 talked with client A and suggested he watch the movie with the other clients and he could change it after the movie was over. He finally agreed, but staff #3 had to counsel him on talking to peers appropriately. Client A told clients B, C, D and F the movie was "dumb" and he wanted to watch something else. Clients B, C, D and F did not respond. When client A went into the living room at 4:00 PM, client E left the room and went to his bedroom. At 4:30 PM client A came to staff #2,</p>			

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	<p>RM, and said client C was yelling at client D. Staff #2, RM, explained client C wasn't yelling, that they were watching "Dukes of Hazzard," on TV. Client A went back into the living room talking about client C yelling and told client C to stop. Client C did not respond.</p> <p>Interview with Client C was conducted on 4/22/14 at 5:20 PM. Client C came to dining area and stated, "That big boy is making me crazy." When asked who that big boy was, client C stated "[Client A]." Client C indicated he was pushed down by client A and got his nose busted. Client C also indicated client A called him names and yelled at him.</p> <p>The review of IDT (Interdisciplinary Team Meeting) notes on 4/21/14 at 4:30 PM indicated on 12/13/13 the team met to discuss the following: "the team met to discuss the fall [client C] had on 12/13/13. [Client C] and another client bumped into each other in the hallway resulting in [client C] falling and hitting his nose. This caused his nose to bleed. The EMS was called and he was taken to [hospital #1] and x-rays were obtained and no fractures present. Neuro evaluation within normal limits. [Client C] was discharged back to the group home, and continued monitoring and head injury tracking was put in place.</p>			

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	<p>[Client C] states he was on his way to the bathroom when another client came out of his room and bumped into him causing him to fall. The team will continue to monitor the situation."</p> <p>Interview with staff #2, RM, on 4/23/14 at 2:30 PM indicated it was Client A that had bumped into client C. Staff #2, RM, indicated client C had been wanting to take a shower since 3:00 AM and because there was only one staff in the house they needed to wait until 6:00 AM when another staff would come in. Staff #2, RM, indicated client A saw client C going to use the restroom and he wanted a shower too and he pushed client A to get the bathroom first.</p> <p>Interview with client H was conducted on 4/23/14 at 4:30 PM. Client H indicated client A made her nervous because he yelled and cursed. Client H stated "I just go to my room when he comes out of his room."</p> <p>Interview with staff #3 on 4/22/14 at 3:00 PM indicated staff tried to keep client A as calm as possible for the other clients living in the home. Staff #3 indicated the other clients avoided client A as much as possible. Staff #3 indicated client A would often get fixated on something and it would be almost impossible to get him</p>			

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	<p>to talk about something else.</p> <p>Staff #2, RM, indicated (4/23/14 at 9:00 AM) client A's roommate was client F, but client A doesn't like him and wants him (F) to move out of the room. Staff #2, RM, indicated the only time client F goes into the bedroom is to sleep. Staff #2, RM, indicated the other clients are all afraid of client A. RM #2 stated client E actually "shakes" when client A starts having a behavior and will ask staff to walk with him if he has to pass (walk beside) client A.</p> <p>Interview with staff #2, RM on 4/23/14 at 2:30 PM indicated client A had behaviors that required the staff to devote full attention to him making it hard for the other clients. Staff #2, RM, indicated client A usually targeted the staff with the physical aggression, but it wasn't unusual for client A to attack the other clients verbally.</p> <p>Review (4/21/14 at 2:30 PM) of the Community Residential Facility Surveyor Worksheet indicated the following ages for the clients living in the home:</p> <ul style="list-style-type: none"> Client A - 52 years old Client B - 67 years old Client C - 88 years old Client D - 73 years old Client E - 57 years old 			

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	<p>Client F - 78 years old Client G - 75 years old Client H - 59 years old.</p> <p>Continued interview with Staff #2, RM, indicated the clients all enjoy doing the same things even with the age differences except for client A. Staff #2, HM, indicated client A didn't want to do anything but play video games and go out to eat. Staff #2, RM, indicated none of the other clients understood or wanted to play video games. Staff #2, RM, indicated the mobility of the other clients was a concern because when client A was agitated he walked rapidly and all the other clients were either in wheelchairs, walkers or were unsteady on their feet.</p> <p>Interview with hospital #1 social workers #1 and #2 on 4/23/14 at 10:45 AM indicated client A had been in the ER a number of times and they were concerned for the safety of the other clients and the staff in the home. They indicated they had tried to get client A into a psychiatric facility but had not been able to find one. Social Worker #2 indicated she had met with client A and each time he was agitated, threatening to harm himself or others.</p> <p>Interview with administrative staff #1 on 4/21/14 at 2:30 PM indicated the home</p>			

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	<p>had some staffing issues but things were calm now. Administrative staff stated "The BSP and medication changes have made a difference, so I have been told, for the better."</p> <p>Review of the Abuse/Neglect/Exploitation Policy and Procedure with a revised date of 7/2/12 was conducted on 4/21/14 at 3:00 PM. The policy indicated "Community Alternatives South East staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect and/or abuse shall be thoroughly investigated. Community Alternatives South East strictly prohibits abuse, neglect and/or exploitation."</p> <p>This federal tag relates to complaint #IN00147210.</p> <p>9-3-2(a)</p>			

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W000156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 1 of 1 BDDS (Bureau of Developmental Disabilities Services) report requiring an investigation involving 1 of 4 sample clients (client A), the facility failed to complete the investigation and report the results to the administrator within 5 working days.</p> <p>Findings include:</p> <p>The BDDS reports were reviewed on 4/21/14 at 3:00 PM. The BDDS report with incident date of 3/3/14 and date of knowledge of 3/5/14 indicated there was an allegation of staff #2, RM (Residential Manager), being verbally inappropriate with client A while in (hospital #1) ER (Emergency Room). The BDDS report also alleged client A reported to the hospital staff that the site nurse and staff #2, RM, were mean to him. The BDDS report indicated the site nurse walked past his room and stuck her tongue out at him and asked the hospital to call the police to assist with client A and she did not care if he went to jail because it was where he needed to be.</p>	W000156	<p>W156: The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within 5 working days of the incident.</p> <p>Corrective Action: (Specific): The investigation team has been in-serviced on completing all investigations and providing the results of the investigation to the administrator or designated representative within 5 working days.</p> <p>How others will be identified: (Systemic): The Program Manager will meet with the investigation team at least weekly to discuss any investigations and ensure that they are completed and the results of the investigation is submitted to the administrator or the designated representative within 5 working days.</p> <p>Measures to be put in place: The investigation team has been in-serviced on completing all investigations and providing the results of the investigation to the administrator or designated representative within 5 working days.</p>	05/25/2014
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	<p>Review (4/21/14 at 3:00 PM) of the 3/28/14 Investigative Summary for the allegation of staff #2, RM, being rude to client A, yelling at him and acting inappropriately while at the local hospital, was substantiated. Review of the Investigative Summary for the site nurse acting inappropriately while at the hospital was substantiated.</p> <p>Interview with administrative staff #2 on 4/25/14 at 11:30 AM indicated the investigation wasn't completed timely because the hospital would not cooperate with letting their staff be interviewed. Administrative staff #2 indicated it took weeks to get all of the information.</p> <p>Interview with administrative staff #1 on 4/25/14 at 1:15 PM indicated the hospital, who made the allegation, would not let the facility interview any of the hospital staff without their lawyer.</p> <p>This federal tag relates to complaint #IN00147210.</p> <p>9-3-2(a)</p>		<p>Monitoring of Corrective Action: The Program Manager will meet with the investigation team at least weekly to discuss any investigations and ensure that they are completed and the results of the investigation is submitted to the administrator or the designated representative within 5 working days.</p> <p>Completion date: 05/25/14</p>		

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W000186	<p>483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (clients A, B, C and D) and 4 additional clients (clients E, F, G and H), the facility failed to ensure there were sufficient direct care staff to manage and supervise clients' physical needs (mobility/safety) and client A's behavioral needs.</p> <p>Findings include:</p> <p>During the observation period on 4/22/14 from 2:00 PM to 5:55 PM, clients E, F and H were at day program at 2:00 PM, while clients A, B, C, D and G were at home doing leisure activities. Clients E, F, and H returned from their day program at 3:00 PM. Staff #2, RM (Residential Manager), staff #3 and staff #6 were in the home. Staff #4 came in at 4:00 PM</p>	W000186	<p>W186: The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Corrective Action: (Specific): The IDT met to review the Behavior Support Plan for Client A, discussed the elopement concerns and determined that a one to one defined as within 5 feet and positioned between Client A and all others clients in the home during waking hours would be added to Client A's BSP. Staffing ratios on night shift were increased so there would always be two staff working to ensure the health and safety of Client A as well as all other clients in the home. IDT's were held with all other clients in the home to review the Bill of Rights, Grievance Policy and Procedure and measures that were put in place in regards to Client</p>	05/25/2014			

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	<p>and staff #6 went home. Client A stayed in his room until 3:50 PM. Client A, who walked with an unsteady gait, told staff he was too tired to get up to take his medication at 4:00 PM. Staff #4 prompted him to stand up and he went to the medication room. At 4:07 PM, staff #2, RM (Residential Manager) asked client A if he would like to go for a walk with her and clients E and H. He said "NO!" Client A told a staff he wanted to play 500 Rummy. Staff #2, RM, asked a staff that had come in at 4:00 PM if she would play the card game with client A. No other clients wanted to play cards with client A. At 4:00 PM, one staff was administering medication, one staff was preparing dinner, and the residential manager indicated she was scheduled to go home at 4:00 PM, but was staying over to help. When client A came out of his room, clients B and E went to other parts of the house.</p> <p>During the observation period on 4/23/14 from 8:20 AM to 10:30 AM, client A had gone back to bed and told staff he didn't want to do anything else when prompted to do another activity. Staff #3 was interviewed on 4/23/14 at 10:00 AM and indicated they (the staff) did not like to push him because he would escalate into a behavior.</p>		<p>A. The local BDDS office was contacted in regards to Client A's placement and citations and a request was made for an immediate search for alternate placement. Client A was moved to a setting commensurate with his needs on 4/25/14.</p> <p>How others will be identified: (Systemic): All client Behavior Support Plans were reviewed to ensure that all preventative and reactive strategies were included to address all target behaviors to ensure that all clients were protected from abuse/neglect in regard to target behaviors of peers. The Residential Manager and the Program Manager will review behavior data for all clients at least monthly to ensure that all plans are effective and clients are free from the potential of abuse/neglect when it relates to target behaviors of peers. All client Behavior Support Plans will be reviewed at least quarterly by the Behavior Review Committee (BRC) to ensure that all plans remain effective.</p> <p>Measures to be put in place: The IDT met to review the Behavior Support Plan for Client A, discussed the elopement concerns and determined that a one to one defined as within 5 feet and positioned between Client A and all others clients in the home during waking hours would be added to Client A's BSP. Staffing ratios on night shift were increased so there would</p>		

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	<p>During the observation time on 4/23/14 from 2:00 PM to 5:30 PM, client A stayed in his room until 4:00 PM. He wanted to watch the TV in the living room, but the other clients were watching a movie. Staff #3 offered to fix his TV in his room to the station he wanted, but he told her he wanted to watch the one in the living room. Staff #2 talked with client A and suggested he watch the movie with the other clients and he could change it after the movie was over. He finally agreed, but staff #3 had to counsel him on talking to peers appropriately. Client A told clients B, C, D and F the movie was "dumb" and he wanted to watch something else. Clients B, C, D and F did not respond. When client A went into the living room at 4:00 PM, client E left the room and went to his bedroom. At 4:30 PM, client A came to staff #2, RM, and said client C was yelling at client D. Staff #2, RM, explained that client C wasn't yelling, that they were watching "Dukes of Hazzard." Client A went back into the living room talking about client C yelling and told client C to stop. Client C did not respond.</p> <p>The facility's reportable incidents and injury reports were reviewed on 4/21/14 at 3:00 PM. Client A's behavioral incidents listed below were the incidents that occurred on the overnight shift:</p>		<p>always be two staff working to ensure the health and safety of Client A as well as all other clients in the home. IDT's were held with all other clients in the home to review the Bill of Rights, Grievance Policy and Procedure and measures that were put in place in regards to Client A. The local BDDS office was contacted in regards to Client A's placement and citations and a request was made for an immediate search for alternate placement. Client A was moved to a setting commensurate with his needs on 4/25/14.</p> <p>Monitoring of Corrective Action: All client Behavior Support Plans were reviewed to ensure that all preventative and reactive strategies were included to address all target behaviors to ensure that all clients were protected from abuse/neglect in regard to target behaviors of peers. The Residential Manager and the Program Manager will review behavior data for all clients at least monthly to ensure that all plans are effective and clients are free from the potential of abuse/neglect when it relates to target behaviors of peers. All client Behavior Support Plans will be reviewed at least quarterly by the Behavior Review Committee (BRC) to ensure that all plans remain effective.</p> <p>Completion date: 05/25/14</p>		

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	<p>12/13/13 at 4:55 AM - "[Client A] and [client C] were both heading to the bathroom at 4:55 AM and ran into each other. [Client C] fell face down on the floor, while [client A] continued on to the bathroom and took a shower. [Client C's] nose was bleeding and 911 was called so [client C] could be evaluated at the Emergency Room."</p> <p>2/20/14 at 6:30 AM - "[Client A] was agitated and became verbally aggressive, which escalated into physical aggression towards staff. The police and EMS (Emergency Services) were called to assist in de-escalating the behavior for everyone's safety. After the police arrived at the home [client A] calmed down and went to his room. No charges were filed and the police left the home. A few hours later [client A] came out of his room and told staff he was leaving, exited the home and started walking down the road. Staff immediately followed him on foot and another staff followed behind in the van and attempted to re-direct him to the home. Staff were finally able to verbally redirect [client A] and he got in the van with staff. Due to his continued agitation and verbal threats the team felt it was warranted that he be transported to the ER (Emergency Room) for an evaluation for in patient</p>			
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	<p>psychiatric evaluation and treatment. [Client A] sustained no injury as a result of the incident. [Client A] was transported to the ER and was evaluated by the physician and the social worker, he was given 2 mg (milligram) IM (injection) of Zyprexa 25 mg IM at the ER and the ER made contact with several inpatient behavioral health units for admission and inpatient placement could not be secured. The hospital kept [client A] in the ER overnight and continued evaluation. His agitation continued off and on throughout the night and the ER physician ordered an injection of Haldol this morning to decrease [client A's] agitation. Shortly after the Haldol was administered [client A's] agitation subsided and he told the hospital staff and the group home nurse that he wanted to go back to the group home. [Client A] was discharged back to the group home with orders to continue current psychotropic medications and follow up with his psychiatrist. He is back home resting comfortably, has had no further signs of agitation and has had appropriate interaction with staff and house mates. His psychiatrist was contacted after discharge and new orders were received for Haldol 5 mg po (by mouth) TID (three times a day) and to decrease Zyprexa to from 15 mg BID (two times a day) to 15 mg at HS (bed time) for</p>			

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	<p>diagnoses of Personality Disorder and Impulse Control Disorder. The team has met to discuss the incident and review current BSP. The team feels that the BSP (Behavior Support Plan) and all reactive and preventative strategies remain appropriate but felt that leaving assigned area should be added with specific preventative and reactive strategies to address. The guardian was aware of the incident, involved in all decisions regarding [client A's] care and has approved the medication changes as well as the revisions of the BSP (Behavior Support Plan). In addition, the revised BSP is in the home and all staff have been trained on the revisions."</p> <p>The internal incident reports were reviewed on 4/21/14 at 4:30 PM. The reports for client A for the overnight shift were as follows:</p> <p>2/20/14 at 5:20 AM - "[Client A] tried to make breakfast. [Client A] punched my right arm. I (staff #5) walked away and let him make breakfast."</p> <p>2/20/14 at 6:30 AM - "[Client A] had been verbally aggressive at working staff about eating more breakfast. He continued verbal aggression and escalated to physical aggression, punched working staff. Residential Manager came through the doorway and consumer</p>			

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	<p>immediately attacked her without warning. He forced her to the floor where he hit her head on the floor and pulled out her hair. While on the floor he attempted to bite her and kicked at her twisting her arm and hitting her back. He choked her neck with his hands before being redirected out of the area. YSIS (You're Safe I'm Safe) was attempted but was not successful. EMS (Emergency Services)/Police were called and [Client A] was verbally redirected. He returned to his bedroom and threw his gaming system 'Playstation' to the floor and smashing it. He then calmed down and returned to bed." No injury to client. Manager taken to ER."</p> <p>2/23/14 at 5:00 AM - "[Client A] wanted to take his shower about 3:30 AM but there were other clients up in the bathrooms at that time. [Client A] became upset and was verbally aggressive towards staff, said he would stab her with a knife. Also threw remote at wall."</p> <p>Interview with staff #2, RM, on 4/23/14 at 9:00 AM stated the staffing level was as follows:</p> <p>"Overnight - 12 Midnight to 8:00 AM - 1 person Day shift - 6:00 AM to 2:00 PM - 1 person Day/afternoon shift - 11:00 AM to</p>			
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	<p>8:00 PM - 1 person Evening shift - 4:00 PM to 12 Midnight." Staff #2, RM indicated she was scheduled to work from 8:00 AM to 4:00 PM, but could come in and work at other times. Staff #2, RM, indicated they needed another staff when client A was having a behavior. Staff #2, RM, stated "Last week he had threatened to leave. He woke at 12:30 AM and only one staff was in the house. [Staff #7] called at 2:00 AM and I got here between 2:30 AM and 3:00 AM." Staff #2, RM, indicated client A's roommate was client F, but client A doesn't like him and wants him (F) to move out of the room. Staff #2, RM, indicated the only time client F goes into the bedroom is to sleep. Staff #2, RM, indicated the other clients are all afraid of client A. RM #2 stated client E actually "shakes" when client A starts having a behavior and will ask staff to walk with him if he has to pass (walk beside) client A.</p> <p>Interview with staff #3 on 4/23/14 at 4:00 PM indicated Client A would come into the living room to watch TV and take the remote (TV's remote control) from the other individuals and turn the station to what he wanted to watch. Staff #3 indicated client A would get upset if staff tried to get him to wait until the show his</p>			

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	<p>peers were watching was over, and he would throw the remote. Staff #3 indicated she was concerned the remote could hit someone and hurt them.</p> <p>This federal tag relates to complaint #IN00147210.</p> <p>9-3-3(a)</p>			
W000407	<p>483.470(a)(1) CLIENT LIVING ENVIRONMENT The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together.</p>			

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	<p>Based on observation, record review and interview for 1 of 4 sampled clients (client A), the facility failed to ensure the client was properly placed in regard to his social, behavioral and psychiatric needs.</p> <p>Findings include:</p> <p>During the observation period on 4/22/14 from 2:00 PM to 6:30 PM, client A was in his room from 2:00 PM to 3:50 PM. Staff indicated he had his snack early and went to bed after snack. Client A came to the living room at 3:50 PM. Client A walked with an unsteady gait and told staff at 4:00 PM he was too tired to get up to take his medication. Staff #4 prompted him to stand up and he went to medication room. At 4:07 PM staff #2, RM (Residential Manager) asked client A if he would like to go for a walk with her and clients E and H. He said "NO!" Client A told a staff he wanted to play 500 Rummy. Staff #2, RM asked a staff that had come in at 4:00 PM if she would play the card game with client A. At 5:00 PM, client A wanted to watch a movie and staff asked clients B, C, D and F if they wanted to watch a movie. They all agreed and client A stayed in the living room with other clients. Dinner was served at 5:25 PM and client E made the comment that he had quit smoking 2 years ago. Client A stated "I never</p>	W000407	<p>W407: The facility must not house clients of grossly different ages, developmental levels and social needs in close proximity or social proximity unless the housing is planned to promote the growth and development of all those housed together.</p> <p>Corrective Action: (Specific): The local BDDS office was contacted in regards to Client A's placement and a request was made for an immediate search for alternate placement. Client A was moved to a setting commensurate with his social, behavioral and psychiatric needs on 4/25/14.</p> <p>How others will be identified: (Systemic): All referrals will be reviewed by the team to ensure that each new admission is appropriately placed in regard to their social, behavioral and psychiatric needs.</p> <p>Measures to be put in place: The local BDDS office was contacted in regards to Client A's placement and a request was made for an immediate search for alternate placement. Client A was moved to a setting commensurate with his social, behavioral and psychiatric needs on 4/25/14.</p> <p>Monitoring of Corrective Action: All referrals will be reviewed by the team to ensure that each new admission is appropriately placed in regard to their social, behavioral and psychiatric needs.</p>	05/25/2014			

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	<p>smoked, it's dumb to smoke." Client E dropped his head and didn't make another comment. Clients B, C, D, E, F, G and H continued eating dinner, but did not make any more comments. Client A continued to talk about how he had never smoked.</p> <p>During the observation period on 4/23/14 from 8:20 AM to 10:30 AM, client A had gone back to bed and told staff he didn't want to do anything else when prompted to do another activity. Staff #3 was interviewed on 4/23/14 at 10:00 AM and indicated the staff did not like to push him because he would escalate into a behavior.</p> <p>During the observation time on 4/23/14 from 2:00 PM to 5:30 PM, client A stayed in his room until 4:00 PM. He wanted to watch the TV in the living room, but the other clients were watching a movie. Staff #3 offered to fix his TV in his room to the station he wanted, but he told her he wanted to watch the one in the living room. Staff #2 talked with client A and suggested he watch the movie with the other clients and he could change it after the movie was over. He finally agreed, but staff #3 had to counsel him on talking to peers appropriately. Client A told clients B, C, D and F the movie was "dumb" and he wanted to watch something else. Clients B, C, D and F</p>		<p>Completion date: 05/25/14</p>				

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	<p>did not respond. When client A went into the living room at 4:00 PM, client E left the room and went into his bedroom. At 4:30 PM client A, came to staff #2, RM, and said client C was yelling at client D. Staff #2, RM explained that client C wasn't yelling, that they were watching "Dukes of Hazzard," Client A went back into the living room talking about client C yelling and told client C to stop. Client C did not respond.</p> <p>The facility's reportable incidents and injury reports were reviewed on 4/21/14 at 3:00 PM regarding Client A's behavioral incidents as follows:</p> <p>12/13/13 at 4:55 AM - "[Client A] and [client C] were both heading to the bathroom at 4:55 AM and ran into each other. [Client C] fell face down on the floor, while [client A] continued on to the bathroom and took a shower. [Client C's] nose was bleeding and 911 was called so [client C] could be evaluated at the Emergency Room."</p> <p>1/2/14 at 8:40 AM - "Staff were getting individuals ready to go to grocery store. [Client A] got upset and hit and pushed staff. Redirection techniques were used and it was decided to take him to ER via EMS (Emergency Service) for an evaluation. Once at the ER, [client A]</p>			
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	<p>was assessed by the psychiatrist and given 15 mg (milligrams) of Zyprexa, diagnosed with schizophrenic exacerbation and orders to have a psych evaluation in the next 3 - 5 days and discharged back to the group home, and was calm. The Director of Health Services contacted [client A's] psychiatrist and he ordered to hold [client A's] Prozac until further notice and increase his Seroquel to 200 mg in AM and noon and 400 mg at bedtime. HRC (Human Rights Committee) and guardian were notified and approved of the medication changes."</p> <p>2/20/14 at 6:30 AM - "[Client A] was agitated and became verbally aggressive, which escalated into physical aggression towards staff. The police and EMS (Emergency Services) were called to assist in de-escalating the behavior for everyone's safety. After the police arrived at the home [client A] calmed down and went to his room. No charges were filed and the police left the home. A few hours later [client A] came out of his room and told staff he was leaving, exited the home and started walking down the road. Staff immediately followed him on foot and another staff followed behind in the van and attempted to re-direct him to the home. Staff were finally able to verbally redirect [client A]</p>			
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	and he got in the van with staff. Due to his continued agitation and verbal threats the team felt it was warranted that he be transported to the ER (Emergency Room) for an evaluation for inpatient psychiatric evaluation and treatment. [Client A] sustained no injury as a result of the incident. [Client A] was transported to the ER and was evaluated by the physician and the social worker, he was given 2 mg (milligram) IM (injection) of Zyprexa 25 mg IM at the ER and the ER made contact with several inpatient behavioral health units for admission and inpatient placement could not be secured. The hospital kept [client A] in the ER overnight and continued evaluation. His agitation continued off and on throughout the night and the ER physician ordered an injection of Haldol this morning to decrease [client A's] agitation. Shortly after the Haldol was administered [client A's] agitation subsided and he told the hospital staff and the group home nurse that he wanted to go back to the group home. [Client A] was discharged back to the group home with orders to continue current psychotropic medications and follow up with his psychiatrist. He is back home resting comfortably, has had no further signs of agitation and has had appropriate interaction with staff and house mates. His psychiatrist was contacted after discharge and new orders				

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	<p>were received for Haldol 5 mg po (by mouth) TID (three times a day) and to decrease Zyprexa to from 15 mg BID (two times a day) to 15 mg at HS (bed time) for diagnoses of Personality Disorder and Impulse Control Disorder. The team has met to discuss the incident and review current BSP. The team feels that the BSP (Behavior Support Plan) and all reactive and preventative strategies remain appropriate but felt that leaving assigned area should be added with specific preventative and reactive strategies to address. The guardian was aware of the incident, involved in all decisions regarding [client A's] care and has approved the medication changes as well as the revisions of the BSP (Behavior Support Plan). In addition, the revised BSP is in the home and all staff have been trained on the revisions."</p> <p>3-3-14 at 3:10 PM - "[Client A] left the home walking toward [name of store] and the site nurse was following him and attempting re-direction back to the home. [Client A] was only wearing socks, refused to put on his shoes or return to the home. The police were contacted for assistance and once they arrived they were able to talk to [client A] and he got into the vehicle with the residential manager. He was transported to the ER for evaluation as a precautionary</p>						

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	measure. [Client A] was assessed by the ER physician and nothing problematic was identified. The physician discharge orders read exposure to cold and to continue care with [name of facility]. The staff attempted to take [client A] back to the home and he refused to leave the hospital. [Client A] began exhibiting behaviors, began yelling, cussing and screaming. The police were called for assistance and [client A] agreed to return to the group home. As the site nurse and residential manager were walking out with [client A], [client A] and the site nurse slipped and fell on the ice. [Client A] sustained no injury as a result of the incident but the site nurse hit her head and required evaluation. Once they went back into the hospital [client A] again refused to leave and again started cussing and yelling, laying on the floor and hitting walls and glass. The staff asked for inpatient psychiatric evaluation and treatment. He was assessed and made threats to harm himself, the hospital attempted to find an inpatient facility for evaluation and treatment and no one would accept [client A]. [Client A] was cleared medically and released to the group home. The team met to discuss the situation and recent behavioral episodes. The team agreed to have his current LOC (Level of Care) reviewed, increase staffing in the home, request a referral to			

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	<p>state contracted psychiatrist, review current BSP and make adjustments as indicated, complete observations at the home by the [facility's name] behavior clinician, re-train staff on BSP (Behavior Support Plan) and consult with current treating psychiatrist regarding current medication regimen and recent behaviors related to diagnosis for possible medication adjustments and continue to monitor and track behaviors. [Client A] is back at the home and has had no further complaints of behaviors."</p> <p>The internal incident reports were reviewed on 4/21/14 at 4:30 PM. The reports for client A were as follows: 2/20/14 at 5:20 AM - "[Client A] tried to make breakfast. [Client A] punched my right arm. I (staff #5) walked away and let him make breakfast." 2/20/14 at 6:30 AM - "[Client A] had been verbally aggressive at working staff about eating more breakfast. He continued verbal aggression and escalated to physical aggression, punched working staff. Residential Manager came through the doorway and consumer immediately attacked her without warning. He forced her to the floor where he hit her head on the floor and pulled out her hair. While on the floor he attempted to bite her and kicked at her</p>			

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	<p>twisting her arm and hitting her back. He choked her neck with his hands before being redirected out of the area. YSIS (You're Safe I'm Safe/behavior management technique) was attempted but was not successful. EMS (Emergency Services)/Police were called and [Client A] was verbally redirected. He returned to his bedroom and threw his gaming system 'Playstation' to the floor and smashing it. He then calmed down and returned to bed. No injury to client. Manager taken to ER."</p> <p>2/20/14 at 10:00 AM - "[Client A] came out of his room and stated to staff he was running away to [name of city]. [Client A] walked out the back door. Staff called RM (Residential Manager) and LPN (Licensed Practical Nurse) for assistance. [Client A] was followed closely down the road for two miles before he became tired and willingly got into the van. After entering van he escalated into physical and verbal aggression and was taken to emergency room. [Client A] was taken to ER for evaluation."</p> <p>2/23/14 at 5:00 AM - "[Client A] wanted to take his shower about 3:30 AM but there were other clients up in the bathrooms at that time. [Client A] became upset and was verbally aggressive towards staff, said he would stab her with a knife. Also threw remote</p>			
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	<p>at wall."</p> <p>2/28/14 at 9:45 AM - "[Client A] was sitting on the couch with his coat on at 8:00 AM. He was supposed to go to [restaurant] for lunch with (LPN). Staff told him several times he had awhile to wait. At 9:30 he started verbally aggressive towards [Residential Manager]. I tried to redirect him and he decided he was leaving anyways. [Client A] was outside and was headed down the drive way when (LPN) showed up. She finally got him to come back. He came inside and sat on the couch and was still very verbal (verbally aggressive) towards her and [Residential Manager]. He then got up and went to his room and laid down. He is still there at this time."</p> <p>3/3/14 at 9:15 AM - "Clients were watching TV (television). [Client A] came in the living room and wanted to change the channel and the others were watching the show. Told [client A] it went off at 10 AM then he could watch something. At this time he starts cursing me and the other staff then starts threatening [client E] and [client B] to hit them and cursing them. Got all clients to their rooms and [client A] stayed in there cursing for another 15 minutes. Now he is in his room."</p> <p>3/3/14 at 3:10 PM - "[Client A] was upset about a shot he got. [Client A] left the house on foot. [Client A] was taken</p>						

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	<p>to the ER." 3/31/14 at 3:30 PM - [Client A] "In room playing a game. Came out of his room started yelling he was not going to eat and cursing. Staff tried to calm him down. He tried to hit staff then said he was leaving. He went to the road. Staff followed. He tried to go on (name of drive). Staff put him in YSIS. He sat down in the yard for a little while than got up and went into the house. Sat in the living room and busted the remote to the TV, Sitting down at this time 4:10 PM."</p> <p>Review of the Community Residential Facility Surveyor Worksheet on 4/21/14 at 2:00 PM indicated the following ages for the clients living in the home:</p> <ul style="list-style-type: none"> Client A - 52 years old Client B - 67 years old Client C - 88 years old Client D - 73 years old Client E - 57 years old Client F - 78 years old Client G - 75 years old Client H - 59 years old. <p>Staff #2, RM, indicated on 4/23/14 at 3:30 PM the clients all enjoy doing the same things even with the age differences except for client A. Staff #2, RM indicated client A didn't want to do anything but play video games and go out</p>						

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	<p>to eat. None of the other clients understand or want to play video games. Staff #2, RM, indicated the mobility of the other clients was a concern because when client A was agitated he walked rapidly and all the other clients were either in wheelchairs, walkers or unsteady on their feet.</p> <p>Interview with Client C was conducted on 4/22/14 at 5:20 PM. Client C came to dining area and stated "That big boy is making me crazy." When asked who that big boy was he stated "[client A]." Client C indicated he was pushed down by client A and got his nose busted. Client C also indicated client A called him names and yelled at him.</p> <p>Interview with staff #3 on 4/23/14 at 4:00 PM indicated Client A would come into the living room to watch TV and take the remote from the other individuals and turn the station to what he wants to watch. Staff #3 indicated he would get upset if they tried to get him to wait until the show they were watch was over and he would throw the remote. Staff #3 indicated she was concerned the remote could hit someone and hurt them.</p> <p>The review of IDT (Interdisciplinary Team Meeting) notes on 4/21/14 at 4:30 PM indicated on 12/13/13 the team met</p>			

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	<p>to discuss the following: "the team met to discuss the fall [client C] had on 12/13/13. [Client C] and another client bumped into each other in the hallway resulting in [client C] falling and hitting his nose. This caused his nose to bleed. The EMS was called and he was taken to (hospital #1) and x-rays were obtained and no fractures present. Neuro evaluation within normal limits. [Client C] was discharged back to the group home, and continued monitoring and head injury tracking was put in place. [Client C] states he was on his way to the bathroom when another client came out of his room and bumped into him causing him to fall. The team will continue to monitor the situation."</p> <p>Review (4/22/14 2:05 PM) of client A's record indicated a BSP/Behavior Support Plan dated 3/20/14. The BSP indicated client A came to his current community placement from an institutional setting which treated individuals with intellectual disabilities and mental illness. The BSP indicated client A displayed the behaviors of isolating himself (staying in his room and refusing activities), suicidal threats, verbal/physical aggression, leaving assigned area (would leave the facility and go to a busy city street), and non-compliance. The BSP indicated his diagnoses included, but were not limited</p>			

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	<p>to, Moderate Intellectual Disability, Impulse Control Disorder, Personality Disorder NOS (Not Otherwise Specified), Depression, Insomnia and EPS (Side Effects of Psychotropic Medication).</p> <p>Interview with staff #2, RM on 4/23/14 at 2:30 PM indicated it was Client A that had bumped into client C. Staff #2, RM indicated client C had been wanting to take a shower since 3:00 AM and because there was only one staff in the house they needed to wait until 6:00 AM when another staff would come in. Staff #2, RM, indicated client A saw client C going to use the restroom and he wanted a shower too and he pushed client A to get the room first.</p> <p>This federal tag relates to complaint #IN00147210.</p> <p>9-3-7(a)</p>			

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

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