

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/23/2012
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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT	STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330
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W0000	<p>This visit was for the investigation of complaints #IN00104104 and #IN00104527.</p> <p>Complaint #IN00104104-Substantiated, Federal/state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W189, W210, W227, W240, W252, W263 and W289.</p> <p>Complaint #IN00104527-Substantiated, Federal/state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W189, W210, W227, W240, W252, W263 and W289.</p> <p>Unrelated deficiencies cited.</p> <p>Dates of Survey: 3/15, 3/16 and 3/23/12</p> <p>Facility Number: 0012632 Provider Number: 15G807 Aim Number: 201045480</p> <p>Surveyors: Paula Chika, Medical Surveyor III-Team Leader Kathy Craig, Medical Surveyor III (3/15/12)</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W0000		

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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	Quality Review completed 3/28/12 by Ruth Shackelford, Medical Surveyor III.				

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W0102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, interview and record review for 2 of 2 sampled clients (A and B), and for 2 additional clients (C and D), the governing body failed to ensure facility staff did not neglect clients in regard to the clients' behaviors. The governing body failed to ensure all allegations of abuse/neglect and/or injuries of unknown origin were reported to state officials and to ensure all allegations of abuse/neglect, client to client aggression and/or injuries of unknown origin were investigated. The governing body failed to ensure the facility had a behavioral consultant monitor/actually be present in the group home as indicated per state law 460 IAC 9-1-2(7) for Extensive Support Need homes.</p> <p>Findings include:</p> <p>1. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for 2 of 2 sampled clients (A and B). The governing body failed to implement its policy and procedures to prevent neglect of clients in regard self-injurious behaviors which resulted in injuries</p>	W0102	<p>CORRECTION: <i>The facility must ensure that specific governing body and management requirements are met.</i></p> <p>Specifically, the governing body has arranged for the Director of Behavior Support to provide 10 hours of on-site support per week until the facility obtains a new behavior specialist. The Director of Behavior Support is coordinating the interdisciplinary team's modification of behavior supports for Clients A and B to appropriately address and prevent self-injury. The origins of injuries discovered on 12/14/11, 12/19/11 and 2/4/12 will be investigated and incidents of client to client aggression which occurred at day service on 1/4/12 and 1/24/12 will be investigated. Additionally Client C's 1/4/12 DDRS Incident Initial Report has been resubmitted to include the fact that during the incident Client A wrapped elastic around her neck, resulting in a red mark.</p> <p><i>PREVENTION: Professional staff will be retrained on agency reporting and investigation protocols and the Director of Behavior Services is overseeing the review and modification of client behavior supports. The Director Supervised Group Living is maintaining an ongoing</i></p>	04/22/2012			

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	<p>and/or potential injuries. The governing body failed to implement its policy and procedures to conduct thorough investigations and to report all allegations of abuse/neglect/injuries of unknown origin. Please see W122.</p> <p>2. The governing body failed to ensure the facility implemented its policy and procedures to prevent neglect of clients A and B in regard to the clients' self-injurious behaviors. The governing body failed to ensure all allegations of possible neglect and/or abuse were reported to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b) (5) and to Adult Protective Services (APS) per IC 12-10-3 for client C. The governing body failed to ensure allegations of abuse, neglect, injuries of unknown origin and/or client to client altercations/abuse were investigated thoroughly in regard to clients A, B, C and D. The governing body failed to ensure the group home had a behavior consultant in the group home for a minimum of 10 hours a week. Please see W149.</p> <p>This federal tag relates to complaints #IN00104104 and #IN00104527.</p>		<p><i>presence at the facility to assure that the governing body provides all necessary resources and oversight. RESPONSIBLE PARTIES: QDDP, Support Associates, Director of Behavior Services, Operations Team</i></p>	

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	9-3-1(a)			

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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on interview and record review for 2 of 2 sampled clients (A and B) and for 2 additional clients (C and D), the governing body failed to exercise general policy and operating direction over the facility to ensure the facility had a behavior consultant/specialist on site for at least 10 hours per week for behavioral services which included direct monitoring, assessment, intervention and staff training for the Extensive Support Needs home.</p> <p>Based on interview and record review for 2 of 2 sampled clients (A and B), the governing body failed to exercise general policy and operating direction over the facility to ensure clients were not neglected in regard to the clients' behaviors. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility reported all allegations of possible abuse/neglect and conducted thorough investigations in regard to client to client aggression incidents and injuries of unknown origin.</p> <p>Findings include:</p>	W0104	<p>CORRECTION: <i>The Governing body must exercise general policy, budget and operating direction over the facility.</i></p> <p>Specifically, the facility is in the process of locating and hiring a new behavior specialist. In the interim, the agency's Director of Behavior Services is supporting the facility with on-site assistance no less than 10 hours per week.</p> <p>PREVENTION: In addition to logging time spent in the facility, the Director of Behavior Services is providing specific updates to the Operations Team as needed but no less than weekly. The Director Supervised Group Living is reviewing documentation on an ongoing basis to assure the facility receives an appropriate level of certified behavior support.</p> <p>RESPONSIBLE PARTIES: Director of Behavior Services, Operations Team</p>	04/22/2012			

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	<p>1. The facility's reportable incident reports, investigations and/or Incident/Accident Reports (IARs) were reviewed on 3/15/12 at 8:40 AM. The facility's reportable incident reports, investigations and/or IARs indicated the following behaviors (not all inclusive):</p> <p>-3/5/12 Client C was talking in a loud voice, playing her music loud and disturbing her peers. The reportable incident report indicated during the medication pass, client C poured her pills out on the floor, and when she was redirected to clean up what she did, client C went to her bedroom and hit her head against the wall causing her nose to bleed. The reportable incident report indicated client C ran out of the group home and continued to demonstrate aggression toward staff and self injury to the point the ambulance had to be called to transport the client to the hospital to be evaluated. The reportable incident report indicated the police came to the group home as well and had to cuff the client until the ambulance arrived.</p> <p>-3/3/12 Client B became upset when she was redirected to eat her lunch before her snack. The reportable incident report indicated client B "flipped table" and started to hit her head on the wall in the bedroom, but the client's helmet</p>			

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	<p>prevented any injuries. The facility staff ended up restraining client B.</p> <p>-2/23/12 "Due to ongoing behavioral outbursts, [client A] (individual supported by ResCare) had been placed on night time 15 minute checks. Staff heard her coughing at 10:30 PM and observed her with a piece of yarn wrapped around her neck, which [client A] was pulling on. When staff intervened, she began hitting her head on the wall and sustained a laceration to her forehead. Staff transported [client A] to [name of hospital] and after evaluation, she was admitted for in-patient psychiatric treatment on 2/24/12...."</p> <p>-2/23/12 (second reportable) client A became upset as a peer was having a behavior and client A started hitting her head on the wall 5 times and bit herself. The reportable incident report indicated "...[Client A] sustained 2 dime sized abrasions on her knuckles on her right hand and a red bite mark on her right forearm...."</p> <p>-2/12/12 "[Client A] (individual we support) came out of her bedroom to staff [staff #1]. [Client A] had a cut on her forehead, approximately 2.5 inches long. [Client A] said that she was hearing voices and she hit her head on the wall to</p>						

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	<p>make the voices stop. The site nurse was contacted and [client A] was taken to [name of hospital] ER (emergency room) for evaluation and treatment...."</p> <p>-2/4/12 Client A was banging her head into the wall as the client had been experiencing nausea and vomiting. The reportable incident report indicated "...Staff intervened immediately but [client A] sustained an open laceration on her forehead. Staff performed first aid, took vital signs which were within normal range and contacted the nurse per protocol. [Client A] told staff she banged her head because she was being bothered by voices...."</p> <p>-1/31/12 Client B became upset in the dining room when redirected to wash her hands. The reportable incident report indicated client B "...flipped over the dining room table and placed it against the wall in an upright position. She sat with her back to the table and began trying to hit her head...." The 1/31/12 reportable incident report indicated client B was placed in a 2 person restraint/hold. The reportable incident report indicated client B calmed down and went to take her shower but began to have a behavior in the bathtub and laid down in the bathtub to try and hit her head. The reportable incident report indicated</p>						

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	<p>"...Staff implemented a 2-person hold while [client B] continued to hit, bite, and spit at staff. [Client B] remained aggressive and all staff present in the home took turns implementing the You're Safe, I'm Safe 2-person hold. [Client B's] behavior specialist was present and directed the team to move forward with plans to secure an in-patient psychiatric admission. Due to the intensity and duration of [client B's] aggression, the team determined that the use of emergency services was necessary to protect [client B] and others. Police responded and transported [client B] to [name of hospital] where she was admitted on an emergency detention...."</p> <p>-1/30/12 Client B refused to leave the day service program. The reportable incident report indicated once in the van, client B began pulling on the straps of the seatbelt and took her shoe off. The 1/30/12 reportable incident report indicated client B chewed on the seat belt all the way to the group home and received a 5 centimeter red area on her shoulder and neck.</p> <p>-1/26/12 Client B was having a behavioral episode at the workshop which resulted in client B demonstrating SIB of hitting her head. The 1/26/12 reportable incident report indicated client B was examined</p>						

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	<p>and treated at the ER for a "...mild head injury...."</p> <p>-1/24/12 Client D picked up a plastic part and threw it at a client at the workshop causing client G to receive a small knot on their forehead with some redness.</p> <p>-1/20/12 Client A received a phone call from her therapist/counselor who requested the client be seen for a follow-up session due to a "...pseudo-seizure on 1/19/12. [Client A] and her team discussed a pattern of increasing auditory hallucinations and suicidal thoughts and plans...her counselor recommended inpatient treatment...[Client A] was admitted to the [name of hospital] psychiatric unit on an emergency detention...."</p> <p>-1/14/12 While client A was at her psychiatric appointment, "...[client A] told the psychiatrist that she has had thoughts of harming herself and had plans to carry out those thoughts. The psychiatrist recommended [client A] be taken to [name of hospital] for evaluation and observation...."</p> <p>-1/10/12 Client A attempted to hit her head on a door and made verbal threats toward staff and "...stated she wanted to die several times...."</p>						

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	<p>-1/6/12 Injury Follow-up Flow Chart indicated on 1/6/12, "[Client C] ripped her panties and tied them around her neck. Red area around neck."</p> <p>-1/4/12 Client D hit a client at the workshop in the arm, who was seated next to her, without any precursors. The reportable incident report indicated client D also hit a client in the back and the back of the client's head with her fist.</p> <p>-12/19/11 "Staff observed [client C] chewing on a broken metal bracelet. When staff redirected her she showed staff a 2 inch scratch and said that she had attempted to harm herself (sic) with the broken bracelet...."</p> <p>-12/17/11 "...[client B] attempted to hit her head against the wall. Staff obtained a pillow to prevent her from injuring her head. She laid on the floor and remained there for a brief period. She then sat up, took off a sock and attempted to place it in her mouth. Staff took the sock from her and she became physically aggressive...(a one person standing restraint) and [client B] began to cry saying she had to use the restroom. Staff released her and walked with her to the bathroom where sat on the floor and attempted to put toilet paper in her mouth.</p>			

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	<p>When staff prevented her from placing non-edible items in her mouth, [client B] attempted to bite her foot...."</p> <p>-12/7/11 Client B sat on the floor and tried to hit the back of her head on the washing machine and then smacked herself with her hands in the face. The reportable incident report indicated a 2 person hold was done to prevent the client from harming herself. The 12/7/11 reportable incident report indicated client B also bit staff on the left leg.</p> <p>-12/5/11 Client B became upset while in the shower when staff wanted to check the water temperature. The reportable incident report indicated client B dropped to the floor and started to bang her head. The reportable incident report indicated facility staff placed a pillow under her head.</p> <p>-12/4/11 "After dinner, [client B] went to her room and laid down in bed. When staff prompted her to take her evening medication, she refused and got up and tried to exit the home's front door. Staff blocked this attempt and she went to the laundry room to attempt to exit through the garage. Staff again prevented her from leaving and she sat on the floor and tried to hit her head on the washer. Staff placed [client B] in an agency approved</p>				

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	<p>two-person hold. She was able to lay on the floor and staff placed a pillow under her head to prevent injury...."</p> <p>Interview with staff #3 on 3/15/12 at 12:18 PM indicated the group home did not have a behavior specialist/consultant (BC) as the BC had quit. Staff #3 stated another BC was to come to the group home "next week."</p> <p>Interview with the Program Coordinator (PC) on 3/15/12 at 2:20 PM indicated the group home did not currently have a behavior consultant as the BC's last day was on 3/7/12. The PC indicated another BC from a different part of the company was to come to the group home the week of 3/19/12. The PC indicated clients A, B, C had recent hospitalizations and/or trips to the ER due to the clients' behaviors. The BC indicated the previous PC came to the group home and monitored the clients.</p> <p>Interview with administrative staff #1, by phone, on 3/16/12 at 10:08 AM indicated the group home did not have a current BC who was actually in the home for 10 hours a week. Administrative staff #1 indicated another BC from a different part of the company would be going to the group home on 3/19/12 and he (administrative staff #1) had been sending</p>						

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	<p>the BC reportable incident reports since the previous BC left on 3/7/12.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of clients A and B in regard to the clients' self-injurious behaviors. Please see W149.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to ensure all allegations of possible neglect and/or abuse were reported to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b) (5) and to Adult Protective Services (APS) per IC 12-10-3 for client C. Please see W153.</p> <p>4. The governing body failed to exercise general policy and operating direction over the facility facility to ensure allegations of abuse, neglect, injuries of unknown origin and/or client to client altercations/abuse were investigated thoroughly in regard to clients A, B, C and D. Please see W154.</p> <p>This federal tag relates to complaints #IN00104104 and #IN00104527.</p>						

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	9-3-1(a)			

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W0122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 2 of 2 sampled clients (A and B). The facility failed to implement its policy and procedures to prevent neglect of clients in regard to self-injurious behaviors which resulted in injuries. The facility failed to implement its policy and procedures to conduct thorough investigations and to ensure all allegations of abuse/neglect/injuries of unknown origin and/or client to client aggression incidents were reported to the administrator and/or to state officials.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The facility failed to implement its policy and procedures to prevent neglect of clients A and B in regard to the clients' self-injurious behaviors. Please see W149. 2. The facility failed to ensure all allegations of possible neglect and/or abuse were reported to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 	W0122	<p>CORRECTION: <i>The facility must ensure that specific client protections requirements are met.</i> Specifically, the team will modify Clients A, B and C's Behavior Support Plans to include self-injury prevention strategies and how staff are to monitor Clients A, B and C to prevent self-injury. The origins of injuries discovered on 12/14/11, 12/19/11 and 2/4/12 will be investigated and incidents of client to client aggression which occurred at day service on 1/4/12 and 1/24/12 will be investigated. Additionally Client C's 1/4/12 DDRS Incident Initial Report has been resubmitted to include the fact that during the incident Client A wrapped elastic around her neck, resulting in a red mark.</p> <p>PREVENTION: Professional staff will be retrained on agency reporting and investigation protocols and the Director of Behavior Services is overseeing the review and modification of client behavior supports. The Director Supervised Group Living is maintaining an ongoing presence at the facility to assure that the facility receives all necessary resources and oversight. RESPONSIBLE PARTIES: QDDP, Support Associates, Director of Behavior Services, Operations Team</p>	04/22/2012

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	<p>460 IAC 9-3-1 (b) (5) and to Adult Protective Services (APS) per IC 12-10-3 for client C. Please see W153.</p> <p>3. The facility failed to ensure allegations of abuse, neglect, injuries of unknown origin and/or client to client altercations/abuse were investigated thoroughly in regard to clients A, B, C and D. Please see W154.</p> <p>This federal tag relates to complaints #IN00104104 and #IN00104527.</p> <p>9-3-2(a)</p>				

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W0149	<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.</p> <p>Based on observation, interview and record review for 2 of 2 sampled clients (A and B), the facility neglected to implement its policy and procedures to prevent neglect of the clients in regard to the clients' self-injurious behaviors.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, Incident/Accident Reports (IARs) and/or investigations were reviewed on 3/15/12 at 8:40 AM. The facility's reportable incident reports, IARs and/or investigations indicated the following:</p> <p>-2/23/12 "Due to ongoing behavioral outbursts, [client A] (individual supported by ResCare) had been placed on night time 15 minute checks. Staff heard her coughing at 10:30 PM and observed her with a piece of yarn wrapped around her neck, which [client A] was pulling on. When staff intervened, she began hitting her head on the wall and sustained a laceration to her forehead. Staff transported [client A] to [name of hospital] and after evaluation, she was admitted for in-patient psychiatric treatment on 2/24/12...."</p>	W0149	<p>CORRECTION: <i>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Specifically, the facility is in the process of locating and hiring a new behavior specialist. In the interim, the agency's Director of Behavior Services is supporting the facility. In that role the Director of Behavior Services is coordinating the interdisciplinary team's modification of behavior supports for Clients A, B and C to appropriately address and prevent self-injury, as well as modifying Client A's behavior supports to include strategies for addressing hallucinations.</i></p> <p><i>PREVENTION: With the assistance of the Director of Behavior Services review of all current behavior supports is underway and modifications to behavior supports will be made as appropriate, per interdisciplinary team consensus. Members of the Operations Team will periodically review behavior supports and compare them with incident reports and other documentation to assure that all current behavioral needs are addressed. RESPONSIBLE PARTIES: QDDP, Support Associates, Director of Behavior</i></p>	04/22/2012			

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	<p>The facility's 2/23/12 IAR indicated "Consumer and staff were sitting in consumers (sic) bedroom after consumer had a behavior. Consumer said "The voices are so strong' she then jumped off her bed and started banging her head on the wall." The 2/23/12 IAR indicated an ambulance was called and the police also responded. The IAR indicated client A had a 2 inch "...bloody gash in the center of forehead...."</p> <p>-2/23/12 (second reportable) client A became upset as a peer was having a behavior and client A started hitting her head on the wall 5 times and bit herself. The reportable incident report indicated "...[Client A] sustained 2 dime sized abrasions on her knuckles on her right hand and a red bite mark on her right forearm...."</p> <p>-2/12/12 "[Client A] (individual we support) came out of her bedroom to staff [staff #1]. [Client A] had a cut on her forehead, approximately 2.5 inches long. [Client A] said that she was hearing voices and she hit her head on the wall to make the voices stop. The site nurse was contacted and [client A] was taken to [name of hospital] ER (emergency room) for evaluation and treatment. [Client A's] room was checked and there were</p>		Services, Operations Team	

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	<p>multiple dents in the wall...." The 2/12/12 reportable incident report indicated once client A was at the hospital, "...[Client A] continued to say that she was hearing voices and the voices told her to hurt herself..." The reportable incident report indicated client A was transferred to another hospital for admission as the current hospital was full. The reportable incident report indicated client A had an active treatment program which addressed the client's hallucinations and a helmet would be ordered to reduce client's A's injuries from the SIB (self-injurious behavior).</p> <p>The facility's internal 2/12/12 incident report indicated client A had "...busted her head open. Staff cleaned [client A] up and [client A] said that she was hearing voices again...."</p> <p>-2/4/12 Client A was banging her head into the wall as the client had been experiencing nausea and vomiting. The reportable incident report indicated "...Staff intervened immediately but [client A] sustained an open laceration on her forehead. Staff performed first aid, took vital signs which were within normal range and contacted the nurse per protocol. [Client A] told staff she banged her head because she was being bothered by voices. Per nurse instructions, staff</p>			

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	<p>transported [client A] to the [name of hospital] and health Services Emergency Department for evaluation and treatment. ER personnel examined [client A], dressed her laceration and released her to SGL (Supported Group Living) staff with a recommendation to follow-up with [client A's] attending psychiatrist. Upon returning home, [client A] observed staff following her Behavior Support Plan (BSP) by sweeping her bedroom to remove objects which she could potentially harm herself. She punched her bedroom wall and went to the living room and sat on the couch. She attempted to hit her head on the wall but staff intervened successfully and prevented her from doing so. She then attempted to pull out her catheter and bit herself...[Client A] received one to one staffing through the evening...."</p> <p>The facility's 2/4/12 IAR indicated client A told staff she was banging her head and punching the wall as "...the voices are too loud in her head." The facility's 2/4/12 Injury Follow-Up Flow Chart indicated "[Client A] was observed beating her head against her bedroom wall repeatedly. [Client A] has reopened the area on her forehead. The cut is 2 in (inches) long in the center and a knot accompanies it as well."</p>			

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	<p>-1/20/12 Client A received a phone call from her therapist/counselor who requested the client be seen for a follow-up session due to a "...pseudo-seizure on 1/19/12. [Client A] and her team discussed a pattern of increasing auditory hallucinations and suicidal thoughts and plans...her counselor recommended inpatient treatment...[Client A] was admitted to the [name of hospital] psychiatric unit on an emergency detention...."</p> <p>-1/14/12 While client A was at her psychiatric appointment, "...[client A] told the psychiatrist that she has had thoughts of harming herself and had plans to carry out those thoughts. The psychiatrist recommended [client A] be taken to [name of hospital] for evaluation and observation...." The 1/14/12 reportable incident report indicated the behavior consultant went to the hospital and spoke with the medical staff. The reportable incident report indicated since client A was not agitated, upset and/or demonstrating SIB, client A was released back to the group home as one on one staffing was put in place. The reportable incident report indicated "...Team will follow up with [client A's] psychiatrist regarding changes in mental status."</p> <p>During the 3/15/12 observation period</p>						

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	<p>between 7 AM and 8:45 AM, at the group home, client A did have a helmet on at 7:00 AM. Client A was sitting at the kitchen table getting ready to eat her breakfast. At 7:15 AM, client A stood and carried her dishes to the kitchen. At 7:21 AM, client A was prompted to get her morning medications. Client A did not have a helmet on. Client A returned to the dining room area after going briefly to her bedroom and sat down and drank a cup of coffee. Client A then went back to her bedroom at 7:44 AM and closed her bedroom door. During the above mentioned observation period, client A did not wear a helmet and/or facility staff did not prompt the client to get her helmet to keep in the dining room/living room area in case it was needed.</p> <p>Client A's record was reviewed on 3/15/12 at 12:10 PM. Client A's Record of Visits (ROV) and/or hospital records indicated the following:</p> <p>-3/5/12 "Follow-up from a hospital stay due to attempting to tie a string around her neck then banging her head on the wall....Diagnosis Head Trauma, PTSD (Post Traumatic Stress Disorder), Auditory hallucination...."</p> <p>-3/6/12 Client A's ROV indicated client A was receiving counseling/therapy for</p>			

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	<p>depression and psychosis. The ROV indicated "[Client A] should refer/read positive statements (the ones she has from today & (and) last time) daily & when needed, upset or in crisis, etc."</p> <p>-3/1/12 Client A saw her psychiatrist for a "Med review" and hospital follow-up. The 3/1/12 ROV indicated client A's diagnosis included, but was not limited to, Schizoaffective Disorder. The psychiatrist recommended the client continue her "current meds."</p> <p>-2/4/12 Emergency Department (ED) note indicated "The patient is a 22-year-old white female who was banging her head against a brick wall approximately 1-1/2 to 2 hours prior to arrival. The staff from her group home brought her in for evaluation of this. She had no loss of consciousness...She does have an abrasion to her forehead...The ED note indicated client A had a "...hematoma (raised area) to her forehead region with an abrasion." The 2/4/12 ED note indicated "...1. Closed head injury...Low mechanism of injury with no neurologic deficits and no concerning historical features. Head injury instructions provided to the staff...."</p> <p>-1/6/12 Client A went for her initial intake to obtain psychiatric/psychological</p>				

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	<p>services. The 1/6/12 attached Treatment Plan (TP) indicated "...Client hears male voices which tells (sic) her to kill self or to harm self. Client has a history of following suggestions..." The 1/6/12 TP indicated client A would have pseudo seizures for attention.</p> <p>Client A's 2/14/12 physician's script indicated "Resident may be fitted for helmet. She is to wear helmet due to increase in frequency of head banging."</p> <p>Client A's 11/21/11 Required Training ABC (Antecedent-Behavior-Consequence) target Behavior Sheet indicated facility staff was conducting/documenting 30 minute checks.</p> <p>Client A's 3/3/12 Behavior Support Plan (BSP) indicated client A had been living at the group home since 11/2011. The 3/3/12 BSP indicated "...During this programming year she has required 3 short term placements at psychiatric facilities as well as multiple visits to medical facilities for injuries sustained during severe behaviors. She has a history of engaging in dangerous behaviors that include striking out at others that has the potential to cause injury, and head banging." The 3/3/12 BSP indicated client A demonstrated</p>						

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	<p>self-injury defined as "any non-suicidal act that causes injury to self (e.g. bang head, scratch self that leaves a mark)...Suicide Threats: threats to harm or kill herself, or indicates having a plan in which to carry out her threats of harm...Suicide Attempt: using sharps or other items to cause bodily harm (i.e. rubbing off skin, cutting open her skin, picking at healing wounds, using items to strangle herself), this also includes if she is attempting to ingest chemicals...."</p> <p>Client A's 3/3/12 BSP indicated client A's diagnoses included, but were not limited to, Major Depression recurrent with Psychotic features, PTSD, and Schizoaffective Disorder. Client A's BSP indicated client A received Depakote, Zoloft, Topamax, Mirtazapine, Benztropine, Saphris for Depression and/or PTSD. Client A's 3/3/12 BSP indicated the following medications addressed the following behaviors:</p> <p>Depakote- physical aggression, SIB, suicide threats and suicide attempts Zoloft- SIB, suicide attempts and threats Topamax-SIB Mirtazapine-SIB Benztropine-SIB and physical aggression Saphris-SIB and aggression</p> <p>The 3/3/12 BSP indicated client A had a "Soft Helmet Protocol" which indicated</p>			

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	<p>client A was to wear her helmet "During all waking hours; at Workshop and while in all community settings. Except while cooking, eating, showering and sleeping; however, this is contingent on mood and displayed behaviors. During periods when the helmet is not being worn, it must be located in an area that is easily accessible to staff in the event of precursor and target behaviors." Client A's 3/3/12 Behavior Support Plan (BSP) indicated client A would be placed on one to one staffing if client A posed a threat to herself or others. Client A's 3/3/12 BSP neglected to indicate how client A was to be monitored/supervised to prevent the client from harming herself before the client actually made an attempt. Client A's BSP did not indicate and/or include the use of 15 minute and/or 30 minute checks to prevent the client's SIB.</p> <p>Client A's 2/1/12 ISP (Individual Support Plan) indicated client A was her own guardian. Client A's ISP indicated client A was admitted to the facility on 12/30/11 after moving in the home in 11/11. Client A's 2/1/12 ISP and/or 3/3/12 BSP indicated the facility neglected to obtain written informed consent in regard to the the use of the soft helmet. Client A's 3/12 data/goal book indicated client A did not have any active treatment objectives and/or data being collected for 3/12.</p>				

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	<p>Client A's 2/1/12 ISP and/or 3/3/12 BSP indicated the facility neglected to collect data in regard to the client's hallucinations. Client A's 2/1/12 ISP and/or 3/1/12 BSP indicated the facility neglected to address the client's identified behavior in regards to auditory hallucinations to prevent the client's SIB. Client A's 2/1/12 ISP and/or 3/3/12 BSP indicated the facility neglected to accurately assess and/or re-assess the client's behavior medications to ensure the client's medications addressed all the client's psychotic/psychiatric diagnoses due to the client's self reported and/or documented hallucinations.</p> <p>Client A's 2/1/12 ISP and/or record neglected to indicate client A's interdisciplinary team (IDT) met and/or documented any meetings in regard to the client's increased SIB which resulted in injuries, ER visits and/or hospitalizations as no notes were present in the chart. Client A's 2/1/12 ISP and/or 3/3/12 BSP also neglected to indicate any documentation and/or follow along by the facility's behavioral consultant in regard to client A's behavioral incidents.</p> <p>Interview with staff #2 on 3/15/12 at 8:10 AM indicated client A demonstrated SIB of head banging. When asked what they were to do when client A demonstrated</p>			

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	<p>SIB, staff #2 stated "Try to prevent from doing. If unsuccessful take to hospital." Staff #2 stated facility staff were conducting 15 minute to 30 minute checks on client A "depending on (client A's) mood." Staff #2 stated "We have to have sights on her every half hour." Staff #2 indicated client A had been doing better since she came back from her last hospitalization.</p> <p>Interview with staff #3 on 3/15/12 at 8:22 AM indicated client A demonstrated head banging and would injure herself as a result. Staff #3 stated client A had a helmet and "wears all the time except when showering, eating or sleeping."</p> <p>Interview with staff #4 on 3/15/12 at 8:25 AM indicated client A was doing better since the client started counseling. Staff #4 indicated client A complained she heard voices and would bang her head to get the voices to stop. Staff #4 indicated client A reported the voices would tell her (client A) to hurt herself. Staff #4 indicated client A put dents in her bedroom wall from banging her head against the wall. Staff #4 indicated client A wore a helmet to protect her head. When asked when client A wore the helmet, staff #4 stated "Oh, she should have it on since she is done with breakfast."</p>						

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	<p>Interview with the Program Coordinator (PC) on 3/15/12 at 2:20 PM indicated client A's behaviors had improved since her last hospitalization 2 to 3 weeks ago. The PC indicated client A demonstrated suicidal threats/attempts and SIB. The PC stated client A should wear her helmet "during waking hours." When asked if client A was being monitored on 15 minute checks, the PC stated "No." The PC indicated the behavior consultant and administrative staff #1 decided the client should be monitored every 15 minutes after an SIB incident occurred. The PC could not locate and/or indicate when the 15 minute checks were discontinued/stopped. The PC indicated client A's BSP did not specifically indicate how client A was to be monitored to prevent the SIB except to be placed on one to one staffing after she made attempts to harm herself. The PC was not able to locate any IDT meeting notes in regard to client A's behaviors/SIB. The PC stated "There were no IDT notes as meetings were done over phone." The PC indicated client A's helmet was put in place after her last hospitalization in 2/12. The PC stated client A indicated client A's SIB of head banging was due to "hearing voices." The PC stated client A's 3/3/12 BSP did not "formally address" client A's auditory</p>						

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	<p>hallucinations. The PC indicated client A saw a counselor therapist for her behaviors. The PC indicated client A's BSP indicated the client's behavioral medications were to treat the client's depression. When asked if client A received any medications to treat the client's hallucinations, The PC indicated the client's medications were increased and/or changed at the last hospitalization. The PC indicated the facility was in the process of getting another psychiatrist to re-assess the client's medications/behaviors. The PC indicated the group home did not currently have a behavior consultant (BC) as the BC's last day was on 3/7/12. The PC indicated another BC from a different part of the company was to come to the group home the week of 3/19/12. The PC indicated she did not know she needed to obtain client A's written informed consent for the use of the helmet. The PC indicated she was not aware client A did not have any active treatment objectives in the goal/ISP book. The PC indicated facility staff had been trained in regard to client A's 2/1/12 ISP, but the PC was not able to locate documentation for such training.</p> <p>2. The facility's reportable incident reports, IARs and/or investigations were reviewed on 3/15/12 at 8:40 AM. The facility's reportable incident reports, IARs</p>			

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	<p>and/or investigations indicated the following:</p> <p>-1/31/12 Client B became upset in the dining room when redirected to wash her hands. The reportable incident report indicated client B "...flipped over the dining room table and placed it against the wall in an upright position. She sat with her back to the table and began trying to hit her head..." The 1/31/12 reportable incident report indicated client B was placed in a 2 person restraint/hold. The reportable incident report indicated client B calmed down and went to take her shower but began to have a behavior in the bathtub and laid down in the bathtub to try and hit her head. The reportable incident report indicated "...Staff implemented a 2-person hold while [client B] continued to hit, bite, and spit at staff. [Client B] remained aggressive and all staff present in the home took turns implementing the You're Safe, I'm Safe 2-person hold. [Client B's] behavior specialist was present and directed the team to move forward with plans to secure an in-patient psychiatric admission. Due to the intensity and duration of [client B's] aggression, the team determined that the use of emergency services was necessary to protect [client B] and others. Police responded and transported [client B] to</p>			

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	<p>[name of hospital] where she was admitted on an emergency detention... [Client B] has engaged in a lengthy pattern of medication refusals which has exacerbated her current behavior crisis...."</p> <p>-1/30/12 Client B refused to leave the day service program. The reportable incident report indicated once in the van, client B began pulling on the straps of the seatbelt and took her shoe off. The 1/30/12 reportable incident report indicated client B chewed on the seat belt all the way to the group home and received a 5 centimeter red area on her shoulder and neck.</p> <p>-1/26/12 Client B was having a behavioral episode at the workshop which resulted in client B demonstrating SIB of hitting her head. The 1/26/12 reportable incident report indicated client B was examined and treated at the ER for a "...mild head injury...with recommendations to talk with [client B's] psych doctor about changing her medication times to later in the morning or considering injectable medication...." The reportable incident report indicated "...[client B] was calm upon her initial arrival home, but became agitated when she wanted a door shut that is to remain open. When staff reopened it, [client B] shut it and held it shut. When staff ignored the behavior, [client</p>			

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	<p>B] sat on the floor and attempted to bite staff (the attempt was blocked) and hit her own head (the attempt was blocked with a pillow)...."</p> <p>-12/17/11 "...[client B] attempted to hit her head against the wall. Staff obtained a pillow to prevent her from injuring her head. She laid on the floor and remained there for a brief period. She then sat up, took off a sock and attempted to place it in her mouth. Staff took the sock from her and she became physically aggressive...(a one person standing restraint) and [client B began to cry saying she had to use the restroom. Staff released her and walked with her to the bathroom where sat on the floor and attempted to put toilet paper in her mouth. When staff prevented her from placing non-edible items in her mouth, [client B] attempted to bite her foot..." The reportable incident report indicated when client B calmed down and went to her bedroom, client B rolled around on the floor, attempted to hit staff and attempted to bang her head. The 12/17/11 reportable incident report indicated "...The IDT will meet to discuss current strategies and determine what modifications may be needed to reduce occurrences...."</p> <p>-12/7/11 Client B sat on the floor and</p>						

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	<p>tried to hit the back of her head on the washing machine and then smacked herself with her hands in the face. The reportable incident report indicated a 2 person hold was done to prevent the client from harming herself. The 12/7/11 reportable incident report indicated client B also bit staff on the left leg. The reportable incident report indicated "...The IDT will meet to discuss current strategies and determine what modifications may be needed to reduce occurrence of injury to responding staff."</p> <p>-12/5/11 Client B became upset while in the shower when staff wanted to check the water temperature. The reportable incident report indicated client B dropped to the floor and started to bang her head. The reportable incident report indicated facility staff placed a pillow under her head.</p> <p>-12/4/11 "After dinner, [client B] went to her room and laid down in bed. When staff prompted her to take her evening medication, she refused and got up and tried to exit the home's front door. Staff blocked this attempt and she went to the laundry room to attempt to exit through the garage. Staff again prevented her from leaving and she sat on the floor and tried to hit her head on the washer. Staff placed [client B] in an agency approved</p>						

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	<p>two-person hold. She was able to lay on the floor and staff placed a pillow under her head to prevent injury...."</p> <p>During the 3/15/12 observation period between 7:00 AM and 8:45 AM, at the group home, client B refused to get up with multiple verbal prompts and physical gestures to take her morning medication. Once client B got up at 7:35 AM, client B came out of her bedroom, went to the bathroom, to the medication room and then came into the dining room. Client B sat at the dining room table and ate her breakfast. Once client B was finished eating at 7:49 AM, client B carried her dishes into the kitchen. Staff #2 asked client B if she wanted to play a game and/or start her laundry. Client B walked in the living room area and retrieved the Monopoly game. Client B then went with staff to her room to get her bed clothes to place in the washer. Client B returned to the dining room with staff #2 and began to play Monopoly. Client B did not wear a helmet and/or have a helmet near her during the above observation period.</p> <p>Client B's record was reviewed on 3/15/12 at 1:15 PM. An 11/17/11 typed letter by a doctor at a mental health center indicated "Due to [client B's] self-injurious behaviors, it is my recommendation that she wear a</p>						

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	<p>protective helmet as a medically necessary effort to protect [client B] against injury associated with these self-injurious behaviors...."</p> <p>Client B's 11/26/11 Record of Visit form indicated client B was seen for "head injury." The Record of Visit form indicated client B had a "...head contusion...."</p> <p>Client B's 2/13/12 physician order/script indicated "Resident may be fitted for helmet. She is to wear helmet due to increase in banging head on wall and furniture." The facility neglected to obtain a helmet for client B in a timely manner to prevent injuries due to client B's SIB.</p> <p>Client B's 3/3/12 Behavior Support Plan (BSP) indicated client B had a history of SIB. Client B's 3/3/12 BSP defined client B's SIB as "Any time [client B] engages in head banging, touching hot items, biting self, throwing herself against doors or walls, attempting to cut herself or ingesting harmful materials and/or objects. Any time, she sits down in parking lots either in front of or in back of vehicles, which she believes are going to move." Client B's 3/3/12 BSP indicated when client B demonstrated "...Self-Injury, Physical Aggression,</p>						

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	<p>Property Destruction</p> <ul style="list-style-type: none"> -Do not overreact, try to maintain a calm and emotionless demeanor -Immediately ensure the health and safety of everybody in the immediate area -In a firm and polite voice ask her to stop the behavior, and redirect her to a quieter area away from others, either outside (back patio) or to her room. Encourage her to use calming strategies (deep breathing, focusing on the positives in her life, etc) -If the behavior persists and she is placing himself (sic) or others in immediate danger implement Your Safe I am Safe. Place yourself between [client B] and her peers. In a calm but firm voice verbally redirect [client B] to a different location/area/activity. Block physical aggression and property destruction. If [client B] is continuing to place herself or others in jeopardy, use the Your Safe I am Safe procedures in the following order: One person hold, Two person hold...." The 3/3/12 BSP indicated "...If [client B] is in the garage -[Client B] is not to be alone while in the garage -Staff must be within arms reach of [client B] to prevent head banging...." Client B's 3/3/12 BSP neglected to have any other specific reactive strategies/interventions in regard to client B's SIB. The intervention of utilizing a 			
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	<p>pillow had not been incorporated into client B's BSP and/or 1/5/12 ISP.</p> <p>Client B's 3/3/12 BSP also indicated client B had a soft helmet protocol which indicated client B's helmet was to be worn: "During all waking hours; at Workshop and while in all community settings. Except while cooking, eating or showering and sleeping; however, this is contingent on mood and displayed behaviors. During periods when the helmet is not being worn, it must be located in an area that is easily accessible to staff in the event of precursor and target behaviors." Client B's 3/3/12 BSP indicated client B was her own guardian. Client B's 3/3/12 BSP and/or record indicated the facility neglected to obtain written informed consent for the use of the helmet. Client B's 1/5/12 ISP and/or record indicated the facility and/or client B's IDT neglected to meet and/or review the client's behaviors as recommended in the above mentioned 12/17/11 and 12/7/11 reportable incident reports. No IDT notes were present in client B's record. Also, client B did not have any documentation by the behavior consultant/specialist in the client's record.</p> <p>Interview with staff #4 on 3/15/12 at 8:25 AM indicated client B would bang her head. Staff #4 also indicated client B</p>			

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	<p>wore a helmet to prevent the client from injuring her when she demonstrated SIB. Staff #4 indicated client B had a behavior plan for the client's SIB.</p> <p>Interview with the PC on 3/15/12 at 2:20 PM indicated client B demonstrated SIB and had been sent out for medical care/services due to the head banging. The PC indicated client B's helmet was initiated in 2/27/12 to prevent the client from injuring herself. The PC indicated she was not aware of the letter written by a doctor in 11/11 for the need for a helmet. The PC indicated client B was to wear her helmet when the client was not eating, sleeping and/or cooking. The PC stated client B's SIB of hitting her head at the workshop and at the group home would some time happen without "precursors." The PC indicated client B's 3/3/12 BSP included interventions for client B's SIB. The PC indicated client B did not have any IDT notes in her record. The PC indicated IDTs were done by phone calls. The PC did not know if the IDTs had been documented. The PC also indicated the facility's BC's last day was on 3/7/12 and a BC from a different part of the agency would be coming to help the week of 3/19/12.</p> <p>Interview with administrative staff #1, by phone, on 3/16/12 at 10:08 AM indicated</p>						

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	<p>the group home did not have a current BC who was actually in the home for 10 hours a week. Administrative staff #1 indicated another BC from a different part of the company would be going to the group home on 3/19/12 and he (administrative staff #1) had been sending the BC reportable incident reports since the previous BC left on 3/7/12. Administrative staff #1 indicated the previous behavior consultant/specialist did keep notes in regard to when the BC was in the home and document on the clients' behaviors. Administrative staff #1 did not provide any additional documentation and/or notes made by the BC.</p> <p>The facility's policy and procedures were reviewed on 3/15/12 at 10:11 AM. The facility's 12/7/10 policy and procedures entitled Abuse, Neglect, Exploitation, Mistreatment indicated "Emotional/physical neglect" was defined as "...failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide the support necessary to an individual's psychological and social well being...and to provide a safe environment...."</p> <p>3. The facility's policy ad procedures were reviewed on 3/15/12 at 10:11 AM. The facility's 12/7/10 policy and</p>				

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	<p>procedures entitled Abuse, Neglect, Exploitation, Mistreatment indicated "...3. Any Adept staff who suspects an individual is the victim of abuse, neglect, mistreatment, or exploitation should immediately notify this suspicion to their Program Coordinator (PC). The PC will then notify the Operations Manager, Licensing and Compliance Coordinator and Director of Operations who will then begin the investigation process. The Executive Director (administrator) and Regional Director will also be notified...." The 12/7/10 policy indicated the facility would notify BDDS of the allegations/reportable incidents. The 12/7/10 policy indicated "...A full investigation will be conducted by ADEPT personnel for incidents occurring residentially (client to client)...."</p> <p>The facility failed to ensure all allegations of neglect/abuse, injuries of unknown origin and/or client to client abuse/incidents were reported to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b) (5) and to Adult Protective Services (APS) per IC 12-10-3 for client C. Please see W153.</p> <p>The facility failed to ensure allegations of</p>			

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	<p>abuse, neglect, injuries of unknown origin and/or client to client altercations/abuse were thoroughly investigated in regard to the incidents involving clients A, B, C and D. Please see W154.</p> <p>This federal tag relates to complaints #IN00104104 and #IN00104527.</p> <p>9-3-2(a)</p>			

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W0153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on 1 of 10 allegations of neglect/abuse, injuries of unknown origin and/or client to client abuse/incidents reviewed, the facility failed to ensure all allegations of possible neglect and/or abuse were reported to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b) (5) and to Adult Protective Services (APS) per IC 12-10-3 for client C.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, Incident/Accident Reports (IARs), Injury Follow-up Flow Charts and/or investigations were reviewed on 3/15/12 at 8:40 AM. The facility's 1/6/12 Injury Follow-up Flow Chart indicated on 1/6/12, "[Client C] ripped her panties and tied them around her neck. Red area around neck." The facility's 1/6/12 Injury Follow-up Flow Chart did not indicate the above mentioned allegation of</p>	W0153	<p>CORRECTION: <i>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately tot he administrator or to other officials in accordance with State law through established procedures. Specifically, the facility has re-submitted a DDRS Incident Report for Client B for the incident that occurred on 1/4/12. The re-submitted report includes information about Client C tying her torn underwear around her neck that had not been reported to administrative staff at the time the original report was submitted. PREVENTION: Direct support staff will be retrained regarding the need to include sufficient detail in facility internal incident reports to assure all pertinent information is reported to state agencies as required, within 24 hours. The QDDP will review all available documentation after incidents occur to assure the team has provided the administrative team with adequate detail to complete a comprehensive report to outside agencies.</i></p> <p>RESPONSIBLE PARTIES: QDDP,</p>	04/22/2012			

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	<p>neglect/abuse was immediately reported to the administrator.</p> <p>Interview with the Program Coordinator (PC) on 3/15/12 at 2:10 PM indicated the 1/6/12 incident with client C should have a reportable incident report and been reported to BDDS per state law. The PC was not able to locate the BDDS report.</p> <p>9-3-2(a)</p>		<i>Support Associates, Operations Team</i>		

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on interview and record review for 5 out of 10 allegations of abuse, neglect, injuries of unknown origin and/or client to client altercations/abuse reviewed, the facility failed to conduct a thorough investigation in regard to the alleged incidents involving clients A, B, C and D.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, internal Incident/Accident Reports (IARs) and/or investigations were reviewed on 3/15/12 at 8:40 AM. The facility's reportable incident reports, IARs and/or investigations indicated the following:</p> <p>-2/4/12 "[Client A] (individual supported by ResCare) approached staff and showed them a cut on her left middle fingernail. She was not able to explain how she sustained the injury....The team has initiated an investigation into the origin of the cut."</p> <p>-1/24/12 Client D picked up a plastic part and threw it at a client at the workshop causing client G to receive a small knot on their forehead with some redness.</p>	W0154	<p>CORRECTION: <i>The facility must have evidence that all alleged violations are thoroughly investigated. Specifically, investigations will be completed for: Client A for the injury of unknown origin discovered on 2/4/12, for Client D's incidents of client to client aggression which occurred at her workshop on 1/4/12 and 1/24/12, Client C's injury of unknown origin discovered on 12/19/11 and Client B's injury of unknown origin discovered on 12/14/11.</i></p> <p>PREVENTION: <i>The Program Coordinator/QDDP will be retrained on the facility's process for investigating incidents of client to client aggression and injuries of unknown origin. The Operations Team has established a tracking system for facility investigations and the QDDP will submit copies of investigation reports and interdisciplinary team follow-up to the Licensure and Compliance Coordinator.</i></p> <p>RESPONSIBLE PARTIES: <i>QDDP, Support Associates, Operations Team</i></p>	04/22/2012			

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	<p>-1/4/12 Client D hit a client at the workshop in the arm, who was seated next to her, without any precursors. The reportable incident report indicated client D also hit a client in the back and the back of the client's head with her fist. The reportable incident report indicated "...No serious injuries resulted from the incident. Some redness was noted on the back of [client E]. Red markings was noted on the upper arm of [client F]...This incident will be investigated internally per agency policy."</p> <p>-12/19/11 "Staff observed [client C] chewing on a broken metal bracelet. When staff redirected her she showed staff a 2 inch scratch and said that she had attempted to harm herwelf (sic) with the broken bracelet. The team has initiated an investigation to determine the accuracy of [client C's] account of how she sustained the injury."</p> <p>-12/14/11 "While assisting [client B] staff discovered a 3 cm (centimeter) circumference cluster of bruises on the right side of her neck above the shoulder. [Client B] did not indicate how she sustained the injury. Recent episodes of aggression and attempted self-injurious behavior did not result in apparent injury at the time of the incidents. The team has initiated an investigation into the origin of</p>						

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	<p>the bruises."</p> <p>The facility's above mentioned reportable incident reports did not indicate any additional documentation of a thorough investigation.</p> <p>Interview with the Program Coordinator (PC) on 3/15/12 at 2:20 PM indicated she was not able to locate any additional information/documentation of an investigation for the above mentioned incidents of client to client aggression and/or injuries on unknown origin.</p> <p>9-3-2(a)</p>				

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W0189	<p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on interview and record review for 1 of 2 sampled clients (A), the facility failed to ensure all staff had been trained in regard to the client's active treatment plan/objectives.</p> <p>Findings include:</p> <p>Client A's record was reviewed on 3/15/12 at 12:10 PM. Client A's 2/1/12 Individual Support Plan (ISP) indicated client A had the following objectives:</p> <ul style="list-style-type: none"> -Read and memorize the side effects of her medications -Respond to verbal prompts and attend day program as scheduled -Identify weekly balance -Complete a task list for cleaning her room that she will follow -Complete each laundry task -Access the grocery store to shop for simple meals 	W0189	<p>CORRECTION: <i>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Specifically, data collection grids are in place for Client A's learning objectives and staff will be trained on implementation of Client A's current supports.</i></p> <p>PREVENTION: <i>Professional staff will be retrained regarding the need to assure staff are trained on current learning objectives for all clients and that data collection grids are in place for each client's individual support plan. Members of the Operations Team will periodically review facility support documents and staff training documentation on an ongoing basis to assure data collection grids are in place and staff have received training as appropriate.</i></p> <p>RESPONSIBLE PARTIES: QDDP, Support Associates, Operations Team</p>	04/22/2012

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	<p>Client A's 3/12 data/goal book indicated client A did not have any active treatment objectives and/or data being collected for 3/12 as the client had no goals/objectives in the book.</p> <p>Interview with staff #3 on 3/15/12 at 12:18 PM stated "[Client A] has no goals. Waiting to see how she will do." Staff #3 indicated client A had demonstrated behaviors since the client was admitted to the group home in 12/11.</p> <p>Interview with the Program Coordinator (PC) on 3/15/12 at 2:20 PM indicated she was not aware client A did not have any active treatment objectives in the goal/ISP book. The PC indicated she was told to do re-do client A's ISP by the Bureau of Developmental Disabilities Services. When asked if facility staff had been trained on client A's ISP, the PC indicated facility staff had been trained in regard to client A's 2/1/12 ISP, but the PC was not able to locate documentation for such training.</p> <p>This federal tag relates to complaints #IN00104104 and #IN00104527.</p> <p>9-3-3(a)</p>				

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W0210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on interview and record review for 1 of 2 sampled clients (A), the client's Interdisciplinary Team (IDT) failed to accurately assess and/or re-assess the client's behavioral medications to ensure they addressed all the client's behavioral/psychiatric needs.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, Incident/Accident Reports (IARs) and/or investigations were reviewed on 3/15/12 at 8:40 AM. The facility's reportable incident reports, IARs and/or investigations indicated the following:</p> <p>-2/23/12 "Due to ongoing behavioral outbursts, [client A] (individual supported by ResCare) had been placed on night time 15 minute checks. Staff heard her coughing at 10:30 PM and observed her with a piece of yarn wrapped around her neck, which [client A] was pulling on. When staff intervened, she began hitting her head on the wall and sustained a laceration to her forehead. Staff transported [client A] to [name of</p>	W0210	<p>CORRECTION: <i>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Specifically, Client A has a new attending psychiatrist and Client A's psychotropic medication regime will be reviewed to assure that all current symptoms of Client A's mental illness are addressed. Additionally, reactive strategies for hallucinations will be added to Client A's Behavior Support Plan.</i></p> <p>PREVENTION: <i>The facility is in the process of locating and hiring a new behavior specialist. In the interim, the agency's Director of Behavior Services is supporting the facility. A review of all current behavior supports is underway and modifications to behavior supports will be made as appropriate, per interdisciplinary team consensus. Members of the Operations Team will periodically review behavior supports and compare them with incident reports and other documentation to assure that all current behavioral needs are addressed.</i></p> <p>RESPONSIBLE PARTIES:</p>	04/22/2012

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	<p>hospital] and after evaluation, she was admitted for in-patient psychiatric treatment on 2/24/12...."</p> <p>The facility's 2/23/12 IAR indicated "Consumer and staff were sitting in consumers (sic) bedroom after consumer had a behavior. Consumer said 'The voices are so strong' she then jumped off her bed and started banging her head on the wall."</p> <p>-2/12/12 "[Client A] (individual we support) came out of her bedroom to staff [staff #1]. [Client A] had a cut on her forehead, approximately 2.5 inches long. [Client A] said that she was hearing voices and she hit her head on the wall to make the voices stop. The site nurse was contacted and [client A] was taken to [name of hospital] ER (emergency room) for evaluation and treatment. [Client A's] room was checked and there were multiple dents in the wall...." The reportable incident report indicated client A had an active treatment program which addressed the client's hallucinations.</p> <p>-2/4/12 Client A was banging her head into the wall as the client had been experiencing nausea and vomiting. The reportable incident report indicated "...Staff intervened immediately but [client A] sustained an open laceration on</p>		<p><i>QDDP, Support Associates, Director of Behavior Services, Operations Team</i></p>				

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	<p>her forehead. Staff performed first aid, took vital signs which were within normal range and contacted the nurse per protocol. [Client A] told staff she banged her head because she was being bothered by voices...."</p> <p>The facility's 2/4/12 IAR indicated client A told staff she was banging her head and punching the wall as "...the voices are too loud in her head."</p> <p>-1/20/12 Client A received a phone call from her therapist/counselor who requested the client be seen for a follow-up session due to a "...pseudo-seizure on 1/19/12. [Client A] and her team discussed a pattern of increasing auditory hallucinations and suicidal thoughts and plans...her counselor recommended inpatient treatment...[Client A] was admitted to the [name of hospital] psychiatric unit on an emergency detention...."</p> <p>Client A's record was reviewed on 3/15/12 at 12:10 PM. Client A's Record of Visits (ROV) and/or hospital records indicated the following:</p> <p>-3/6/12 Client A's ROV indicated client A was receiving counseling/therapy for depression and psychosis. The ROV indicated "[Client A] should refer/read</p>						

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	<p>positive statements (the ones she has from today & (and) last time) daily & when needed, upset or in crisis, etc."</p> <p>-3/1/12 Client A saw her psychiatrist for a "Med review" and hospital follow-up. The 3/1/12 ROV indicated client A's diagnosis included, but was not limited to, Schizoaffective Disorder." The psychiatrist recommended the client continue her "current meds."</p> <p>-1/6/12 Client A went for her initial intake to obtain psychiatric/psychological services. The 1/6/12 attached Treatment Plan (TP) indicated "...Client hears male voices which tells (sic)her to kill self or to harm self. Client has a history of following suggestions..." The 1/16/12 TP indicated client A would have pseudo seizures for attention.</p> <p>Client A's 3/3/12 Behavior Support Plan (BSP) indicated client A had been living at the group home since 11/2010. The 3/3/12 BSP indicated "...During this programming year she has required 3 short term placements at psychiatric facilities as well as multiple visits to medical facilities for injuries sustained during severe behaviors. She has a history of engaging in dangerous behaviors that include striking out at others that has the potential to cause</p>						

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	<p>injury, and head banging." Client A's 3/3/12 BSP indicated client A's diagnoses included, but were not limited to, Major Depression recurrent with Psychotic features, PTSD, and Schizoaffective Disorder. Client A's BSP indicated client A received Depakote, Zoloft, Topamax, Mirtazapine, Benztropine, Saphris for Depression and/or PTSD. Client A's 3/3/12 BSP indicated the following medications addressed the following behaviors:</p> <p>Depakote- physical aggression, SIB, suicide threats and suicide attempts Zoloft- SIB, suicide attempts and threats Topamax-SIB Mirtazapine-SIB Benztropine-SIB and physical aggression Saphris-SIB and aggression</p> <p>Client A's 2/1/12 ISP and/or 3/3/12 BSP indicated the facility was not collecting data in regard to the client's hallucinations. Client A's 2/1/12 and/or 3/3/12 BSP indicated the facility failed to obtain an accurate assessment and/or failed to re-assess the client's behavior medications to ensure the client's medications addressed all the client's psychotic/psychiatric diagnoses due to the client's self reported and/or documented hallucinations.</p>			

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	<p>Interview with staff #4 on 3/15/12 at 8:25 AM indicated client A was doing better since the client started counseling. Staff #4 indicated client A complained she heard voices and would bang her head to get the voices to stop. Staff #4 indicated client A reported the voices would tell her (client A) to hurt herself. Staff #4 indicated client A put dents in her bedroom wall from banging her head against the wall.</p> <p>Interview with the Program Coordinator (PC) on 3/15/12 at 2:20 PM stated client A's SIB of head banging was due to "hearing voices." The PC indicated the client's medications were increased and/or changed at the last hospitalization. The PC indicated the facility was in the process of getting another psychiatrist to re-assess the client's medications/behaviors.</p> <p>This federal tag relates to complaints #IN00104104 and #IN00104527.</p> <p>9-3-4(a)</p>				

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W0227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on interview and record review for 1 of 2 sampled clients (A), the client's Individual Support Plan (ISP) failed to address the client's identified behavioral need in regard to hallucinations.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, Incident/Accident Reports (IARs) and/or investigations were reviewed on 3/15/12 at 8:40 AM. The facility's reportable incident reports, IARs and/or investigations indicated the following:</p> <p>-2/23/12 "Due to ongoing behavioral outbursts, [client A] (individual supported by ResCare) had been placed on night time 15 minute checks. Staff heard her coughing at 10:30 PM and observed her with a piece if yarn wrapped around her neck, which [client A] was pulling on. When staff intervened, she began hitting her head on the wall and sustained a laceration to her forehead. Staff transported [client A] to [name of hospital] and after evaluation, she was admitted for in-patient psychiatric</p>	W0227	<p>CORRECTION: <i>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment. Specifically, for Client A, reactive strategies for hallucinations will be added to Client A's Behavior Support Plan. PREVENTION: The facility is in the process of locating and hiring a new behavior specialist. In the interim, the agency's Director of Behavior Services is supporting the facility. A review of all current behavior supports is underway and modifications to behavior supports will be made as appropriate, per interdisciplinary team consensus. Members of the Operations Team will periodically review behavior supports and compare them with incident reports and other documentation to assure that all current behavioral needs are addressed.</i></p> <p>RESPONSIBLE PARTIES: <i>QDDP, Support Associates, Director of Behavior Services, Operations Team</i></p>	04/22/2012

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	<p>treatment on 2/24/12...."</p> <p>The facility's 2/23/12 IAR indicated "Consumer and staff were sitting in consumers (sic) bedroom after consumer had a behavior. Consumer said 'The voices are so strong' she then jumped off her bed and started banging her head on the wall."</p> <p>-2/12/12 "[Client A] (individual we support) came out of her bedroom to staff [staff #1]. [Client A] had a cut on her forehead, approximately 2.5 inches long. [Client A] said that she was hearing voices and she hit her head on the wall to make the voices stop. The site nurse was contacted and [client A] was taken to [name of hospital] ER (emergency room) for evaluation and treatment. [Client A's] room was checked and there were multiple dents in the wall...." The reportable incident report indicated client A had an active treatment program which addressed the client's hallucinations.</p> <p>-2/4/12 Client A was banging her head into the wall as the client had been experiencing nausea and vomiting. The reportable incident report indicated "...Staff intervened immediately but [client A] sustained an open laceration on her forehead. Staff performed first aid, took vital signs which were within normal</p>						

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	<p>range and contacted the nurse per protocol. [Client A] told staff she banged her head because she was being bothered by voices...."</p> <p>The facility's 2/4/12 IAR indicated client A told staff she was banging her head and punching the wall as "...the voices are too loud in her head."</p> <p>-1/20/12 Client A received a phone call from her therapist/counselor who requested the client be seen for a follow-up session due to a "...pseudo-seizure on 1/19/12. [Client A] and her team discussed a pattern of increasing auditory hallucinations and suicidal thoughts and plans...her counselor recommended inpatient treatment...[Client A] was admitted to the [name of hospital] psychiatric unit on an emergency detention...."</p> <p>Client A's record was reviewed on 3/15/12 at 12:10 PM. Client A's Record of Visits (ROV) and/or hospital records indicated the following:</p> <p>-3/5/12 "Follow-up from a hospital stay due to attempting to tie a string around her neck then banging her head on the wall....Diagnosis Head Trauma, PTSD (Post Traumatic Stress Disorder), Auditory hallucination...."</p>			

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	<p>-1/6/12 Client A went for her initial intake to obtain psychiatric/psychological services. The 1/6/12 attached Treatment Plan (TP) indicated "...Client hears male voices which tells her to kill self or to harm self. Client has a history of following suggestions...."</p> <p>Client A's 3/3/12 Behavior Support Plan (BSP) indicated client A had been living at the group home since 11/2010. The 3/3/12 BSP indicated "...During this programming year she has required 3 short term placements at psychiatric facilities as well as multiple visits to medical facilities for injuries sustained during severe behaviors. She has a history of engaging in dangerous behaviors that include striking out at others that has the potential to cause injury, and head banging." The 3/3/12 BSP indicated client A demonstrated self-injury defined as "any non-suicidal act that causes injury to self (e.g. bang head, scratch self that leaves a mark)...Suicide Threats: threats to harm or kill herself, or indicates having a plan in which to carry out her threats of harm...Suicide Attempt: using sharps or other items to cause bodily harm (i.e. rubbing off skin cutting open her skin, picking at healing wounds, using items to strangle herself), this also includes if she</p>						

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	<p>is attempting to ingest chemicals...."</p> <p>Client A's 3/3/12 BSP indicated client A's diagnoses included, but were not limited to, Major Depression recurrent with Psychotic features, PTSD, and Schizoaffective Disorder. Client A's 3/3/12 BSP did not specifically address the client's identified behavioral need in regard to hallucinations.</p> <p>Interview with staff #4 on 3/15/12 at 8:25 AM indicated client A was doing better since the client started counseling. Staff #4 indicated client A complained she heard voices and would bang her head to get the voices to stop. Staff #4 indicated client A reported the voices would tell her (client A) to hurt herself. Staff #4 indicated client A put dents in her bedroom wall from banging her head against the wall.</p> <p>Interview with the Program Coordinator (PC) on 3/15/12 at 2:20 PM stated client A's SIB of head banging was due to "hearing voices." The PC stated client A's 3/3/12 BSP did not "formally address" client A's auditory hallucinations. The PC indicated client A saw a counselor therapist for her behaviors.</p> <p>This federal tag relates to complaints #IN00104104 and #IN00104527.</p>						

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W0240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on interview and record review for 1 of 2 sampled clients (A), the facility failed to ensure the client's Individual Support Plan (ISP) included/indicated how facility staff was to monitor the client to prevent the client from demonstrating SIB.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, Incident/Accident Reports (IARs) and/or investigations were reviewed on 3/15/12 at 8:40 AM. The facility's reportable incident reports, IARs and/or investigations indicated the following:</p> <p>-2/23/12 "Due to ongoing behavioral outbursts, [client A] (individual supported by ResCare) had been placed on night time 15 minute checks. Staff heard her coughing at 10:30 PM and observed her with a piece of yarn wrapped around her neck, which [client A] was pulling on. When staff intervened, she began hitting her head on the wall and sustained a laceration to her forehead. Staff transported [client A] to [name of hospital] and after evaluation, she was admitted for in-patient psychiatric</p>	W0240	<p>CORRECTION: <i>The individual program plan must describe relevant interventions to support the individual toward independence.</i> Specifically, the team will modify Client A's Behavior Support Plan to include self-injury prevention strategies and how staff is to monitor Client A to prevent self-injury.</p> <p>PREVENTION: In addition to the changes to client A's Behavior Supports, the team will modify Client B and Client C's Behavior Support Plans to include self-injury prevention strategies and how staff is to monitor Clients B and C to prevent self-injury. A review of all current behavior supports is underway and modifications to behavior supports will be made as appropriate, per interdisciplinary team consensus. Members of the Operations Team will periodically review behavior supports and compare them with incident reports and other documentation to assure that all current behavioral needs are addressed.</p> <p>RESPONSIBLE PARTIES: QDDP, Support Associates, Director of Behavior Services, Operations Team</p>	04/22/2012			

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	<p>treatment on 2/24/12...."</p> <p>The facility's 2/23/12 IAR indicated "Consumer and staff were sitting in consumers (sic) bedroom after consumer had a behavior. Consumer said 'The voices are so strong' she then jumped off her bed and started banging her head on the wall." The 2/23/12 IAR indicated an ambulance was called and the police also responded. The IAR indicated client A had a 2 inch "...bloody gash in the center of forehead...."</p> <p>-2/23/12 (second reportable) client A became upset as a peer was having a behavior and client A started hitting her head on the wall 5 times and bit herself. The reportable incident report indicated "...[Client A] sustained 2 dime sized abrasions on her knuckles on her right hand and a red bite mark on her right forearm...."</p> <p>-2/12/12 "[Client A] (individual we support) came out of her bedroom to staff [staff #1]. [Client A] had a cut on her forehead, approximately 2.5 inches long. [Client A] said that she was hearing voices and she hit her head on the wall to make the voices stop. The site nurse was contacted and [client A] was taken to [name of hospital] ER (emergency room) for evaluation and treatment. [Client A's]</p>				

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	<p>room was checked and there were multiple dents in the wall...."</p> <p>Client A's record was reviewed on 3/15/12 at 12:10 PM. Client A's 11/21/11 Required Training ABC (Antecedent-Behavior-Consequence) target Behavior Sheet indicated facility staff was conducting/documenting 30 minute checks on client A.</p> <p>Client A's 3/3/12 Behavior Support Plan (BSP) indicated client A would be placed on one to one staffing if client A posed a threat to herself or others. Client A's 3/3/12 BSP failed to indicate how client A was to be monitored/supervised to prevent the client from harming herself before the client actually made an attempt. Client A's BSP did not indicate and/or include the use of 15 minute and/or 30 minute checks to prevent the client's SIB.</p> <p>Interview with the Program Coordinator (PC) on 3/15/12 at 2:20 PM indicated client A demonstrated suicidal threats/attempts and SIB. The PC indicated facility staff were to monitor the client every half hour per the client's ABC sheets. When asked if client A was being monitored/on 15 minute checks, the PC stated "No." The PC indicated the behavior consultant and administrative</p>						

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	<p>staff #1 decided the client should be monitored every 15 minutes after an SIB incident occurred. The PC could not locate and/or indicate when the 15 minute checks were discontinued/stopped. The PC indicated client A's BSP did not specifically indicate how client A was to be monitored to prevent the SIB except to be placed on one to one staffing after she made attempts to harm herself.</p> <p>This federal tag relates to complaints #IN00104104 and #IN00104527.</p> <p>9-3-4(a)</p>			

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W0252	<p>483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>Based on interview and record review for 1 of 2 sampled clients (A), the facility failed to collect data in regard to the client's objectives as specified in the client's Individual Support Plan (ISP).</p> <p>Findings include:</p> <p>Client A's record was reviewed on 3/15/12 at 12:10 PM. Client A's 2/1/12 ISP indicated client A had the following objectives:</p> <ul style="list-style-type: none"> -Read and memorize the side effects of her medications -Respond to verbal prompts and attend day program as scheduled -Identify weekly balance -Complete a task list for cleaning her room that she will follow -Complete each laundry task -Access the grocery store to shop for simple meals 	W0252	<p>CORRECTION: <i>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. Specifically, data collection grids are in place for Client A's learning objectives.</i></p> <p>PREVENTION: <i>Professional staff will be retrained regarding the need to assure that data collection grids are in place for all learning objectives in each client's individual support plan. Members of the Operations Team will periodically review facility support documents to assure data collection grids are in place</i></p> <p>RESPONSIBLE PARTIES: QDDP, Support Associates, Operations Team</p>	04/22/2012	

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	<p>Client A's 3/12 data/goal book indicated client A did not have any active treatment objectives and/or data being collected for 3/12 as the client had no goals/objectives in the book.</p> <p>Interview with staff #3 on 3/15/12 at 12:18 PM stated "[Client A] has no goals. Waiting to see how she will do." Staff #3 indicated client A had demonstrated behaviors since the client was admitted to the group home in 12/11.</p> <p>Interview with the Program Coordinator (PC) on 3/15/12 at 2:20 PM indicated she was not aware client A did not have any active treatment objectives in the goal/ISP book. The PC indicated she was told to do re-do client A's ISP by the Bureau of Developmental Disabilities Services. The PC indicated the staff did not tell her there were no goals in the goal/ISP book.</p> <p>This federal tag relates to complaints #IN00104104 and #IN00104527.</p> <p>9-3-4(a)</p>				

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W0263	<p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on interview and record review for 2 of 2 sampled clients (A and B) with restrictive programs, the facility failed to obtain written informed consent for the restrictive programs/interventions.</p> <p>Findings include:</p> <p>1. Client A's record was reviewed on 3/15/12 at 12:10 PM. Client A's 2/14/12 physician's script indicated "Resident may be fitted for helmet. She is to wear helmet due to increase frequency of head banging."</p> <p>Client A's 3/3/12 Behavior Support Plan (BSP) indicated client A had a "Soft Helmet Protocol" which indicated client A was to wear her helmet "During all waking hours; at Workshop and while in all community settings. Except while cooking, eating, showering and sleeping; however, this is contingent on mood and displayed behaviors. During periods when the helmet is not being worn, it must be located in an area that is easily accessible to staff in the event of precursor and target behaviors."</p>	W0263	<p>CORRECTION: <i>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Specifically, the team will obtain written informed consent for the the use of helmets for Client A and Client B. PREVENTION: Professional staff will be retrained regarding the need to obtain prior written informed consent from clients and/or their legal representatives for all restrictive programs. Members of the Operations Team will periodically review support and consent documents on an ongoing basis to assure the team has obtained written informed consent for all restrictive programs for all clients.</i></p> <p>RESPONSIBLE PARTIES: <i>QDDP, Support Associates, Operations Team, Human rights Committee</i></p>	04/22/2012			

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	<p>Client A's 2/1/12 ISP (Individual Support Plan) indicated client A was her own guardian. Client A's 2/1/12 ISP and/or 3/3/12 BSP indicated the facility failed to obtain written informed consent in regard to the the use of the soft helmet.</p> <p>2. Client B's record was reviewed on 3/15/12 at 1:15 PM. An 11/17/11 typed letter by a doctor at a mental health center indicated "Due to [client B's] self-injurious behaviors, it is my recommendation that she wear a protective helmet as a medically necessary effort to protect [client B] against injury associated with these self-injurious behaviors...."</p> <p>Client B's 2/13/12 physician order/script indicated "Resident may be fitted for helmet. She is to wear helmet due to increase in banging head on wall and furniture."</p> <p>Client B's 3/3/12 Behavior Support Plan (BSP) indicated client B had a soft helmet protocol which indicated client B's helmet was to be worn: "During all waking hours; at Workshop and while in all community settings. Except while cooking, eating or showering and sleeping; however, this is contingent on mood and displayed behaviors. During periods when the helmet is not being</p>			

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	<p>worn, it must be located in an area that is easily accessible to staff in the event of precursor and target behaviors." Client B's 3/3/12 BSP indicated client B was her own guardian. Client B's 3/3/12 BSP and/or record did not indicate the facility obtained written informed consent for the use of the helmet.</p> <p>Interview with the PC on 3/15/12 at 2:20 PM indicated client A and B demonstrated SIB and had been sent out for medical care/services due to the head banging. The PC indicated clients A and B's helmets were initiated on 2/27/12 to prevent the clients from injuring themselves. The PC indicated she did not know she needed to obtain client A and B's written informed consent for the use of the helmet.</p> <p>This federal tag relates to complaints #IN00104104 and #IN00104527.</p> <p>9-3-4(a)</p>						

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W0289	<p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.</p> <p>Based on interview and record review for 1 of 2 sampled clients (B), the facility failed to ensure the client's Individual Support Plan (ISP) included specific interventions/techniques staff were to utilize to prevent the client from demonstrating self-injurious behavior (SIB).</p> <p>Findings include:</p> <p>The facility's reportable incident reports, IARs and/or investigations were reviewed on 3/15/12 at 8:40 AM. The facility's reportable incident reports, IARs and/or investigations indicated client B demonstrated SIB of head banging and/or biting herself on 1/13/12, 1/30/12, 1/26/12, 12/17/11, 12/7/11, 12/5/11 and 12/4/11. The above mentioned reportable incident reports indicated facility staff would at times, utilize pillows to block/keep the client from injuring herself.</p> <p>Client B's record was reviewed on 3/15/12 at 1:15 PM. Client B's 3/3/12</p>	W0289	<p>CORRECTION: <i>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan.</i> Specifically, the team will modify Client B's Behavior Support Plan to include self-injury prevention strategies and how staff is to monitor Client A to prevent self-injury.</p> <p>PREVENTION: In addition to the changes to client B's Behavior Supports, the team will modify Client A and Client C's Behavior Support Plans to include self-injury prevention strategies and how staff is to monitor Clients A and C to prevent self-injury. A review of all current behavior supports is underway and modifications to behavior supports will be made as appropriate, per interdisciplinary team consensus. Members of the Operations Team will periodically review behavior supports and compare them with incident reports and other documentation to assure that all current behavioral needs are addressed.</p> <p>RESPONSIBLE PARTIES: QDDP, Support Associates, Director of Behavior Services,</p>	04/22/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G807		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/23/2012	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES ADEPT				STREET ADDRESS, CITY, STATE, ZIP CODE 213 W WATER ST CENTERVILLE, IN 47330			
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	<p>Behavior Support Plan (BSP) indicated client B had a history of SIB. Client B's 3/3/12 BSP defined client B's SIB as "Any time [client B] engages in head banging, touching hot items, biting self, throwing herself against doors or walls, attempting to cut herself or ingesting harmful materials and/or objects. Any time, she sits down in parking lots either in front of or in back of vehicles, which she believes are going to move." Client B's 3/3/12 BSP indicated when client B demonstrated "...Self-Injury, Physical Aggression, Property Destruction</p> <ul style="list-style-type: none"> -Do not overreact, try to maintain a calm and emotionless demeanor -Immediately ensure the health and safety of everybody in the immediate area -In a firm and polite voice ask her to stop the behavior, and redirect her to a quieter area away from others, either outside (back patio) or to her room. Encourage her to use calming strategies (deep breathing, focusing on the positives in her life, etc) -If the behavior persists and she is placing himself (sic) or others in immediate danger implement Your Safe I am Safe. Place yourself between [client B] and her peers. In a calm but firm voice verbally redirect [client B] to a different location/area/activity. Block physical aggression and property destruction. If [client B] is continuing to place herself or 		Operations Team				

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	<p>others in jeopardy, use the Your Safe I am Safe procedures in the following order: One person hold, Two person hold..." The 3/3/12 BSP indicated "...If [client B] is in the garage -[Client B] is not to be alone while in the garage -Staff must be within arms reach of [client B] to prevent head banging...." Client B's 3/3/12 BSP did not include specific reactive strategies/interventions in regard to client B's SIB. The intervention of utilizing a pillow had not been incorporated into client B's BSP and/or 1/5/12 Individual Support Plan.</p> <p>Interview with staff #4 on 3/15/12 at 8:25 AM indicated client B would bang her head. Staff #4 also indicated client B wore a helmet to prevent the client from injuring her when she demonstrated SIB. Staff #4 indicated client B had a behavior plan for the client's SIB.</p> <p>Interview with the PC on 3/15/12 at 2:20 PM indicated client B demonstrated SIB and had been sent out for medical care/services due to the head banging. The PC indicated client B's helmet was initiated in 2/27/12 to prevent the client from injuring herself. The PC indicated client B's 3/3/12 BSP included specific interventions which addressed the client's SIB.</p>			

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	This federal tag relates to complaints #IN00104104 and #IN00104527. 9-3-5(a)				